SOUTHINGTON PUBLIC SCHOOLS
EMPLOYEE *WORK RELATED* ACCIDENT REPORT

***Employee*: Immediately following a *work related* accident, complete this report and have your administrator/supervisor complete and sign the shaded section at bottom.**

Injured Employee's Name: _____ School: _____ Dept: _____

Injured Employee's Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Work Phone #: _____ Date of Birth: _____

Social Security #: _____ Occupation: _____ Date of Hire: _____

Date of Accident: _____ Time Employee Began Work: _____ a.m. ☐ p.m.☐ Time of Accident: _____ a.m. ☐ p.m.☐

Indicate part(s) of body affected: _____

Describe fully how the accident occurred and what employee was doing when injured. Include description of work and tools in use: _____

_____

_____

_____

_____

Personal Protective Equipment (PPE) Required: *Yes* ☐ *No* ☐ Was Personal Protective Equipment (PPE) In Use? *Yes* ☐ *No* ☐

If no PPE in use when required, explain why not: _____

Exposure to Bloodborne Pathogens: **If Yes, complete the *BLOOD/BODY FLUID EXPOSURE INCIDENT REPORT.***
Yes ☐ *No* ☐ If *Yes*, facility sent to: _____

List all known factors that contributed to this incident: _____

_____

_____

Please check all that apply: First Aid ☐ Doctor Visit ☐ Lost Time Injury ☐

Treatment Administered: _____ Date and Time of First Treatment: _____

School Nurse Treatment Administered: _____

_____

If seen by physician, please provide the name and address of physician/health care provider: _____

_____

If injury resulted in *days away from work:* Date incapacity began: _____ Date returning to work: _____

Witness(s) name: _____

Signature of Employee: _____ Date of this report: _____

***Note to Employee*: Send all medical forms received for treatment associated with this accident to the Personnel Secretary at the Board of Education Central Office.**

********** Section Below to be completed by Supervisor **********

Can corrective action be taken to prevent a reoccurrence? *Yes* ☐ *No* ☐

What corrective action will be initiated to prevent a reoccurrence? _____

_____

_____

Provide Copies to: ☐ Principal/Supervisor ☐ Personnel Office ☐ Operations Administrator
If *Bloodborne Pathogens Exposure* is *Yes*, send additional copies to: ☐ Personnel Director ☐ Nursing Supervisor

Signature of Supervisor: _____ **Date:** _____

First notified of the injury: Date: _____ **Time:** _____ **a.m. ☐ p.m. ☐**