U.S.D. 481 Accident/Injury Reporting Procedures

Employee

1. Immediately report all accidents and injuries to your immediate supervisor (within 24 hours or as soon as possible). Someone may report the accident on your behalf if you are not able to report it yourself.

2. Seek medical attention at the Designated Health Care Provider (DCHP). These are the Herington Municipal Hospital, the Memorial Hospital in Abilene, Morris County Hospital in Council Grove.

   If your supervisor is unavailable, seek medical attention. Report the injury to your supervisor as soon as possible, but no later than the beginning of the next business day. Contact superintendent if your supervisor is still unavailable.

3. Immediately following your doctor's visit, return the release slip to your immediate supervisor.

4. Complete the Report by Injured Employee.

Supervisor

1. Direct the injured employee to DHCP listed above.
   Notify the district office of the accident as soon as you have taken care of the injured employee.

2. Give the employee a Notice of Injury form to take to DHCP.

3. Obtain a release slip from the employee.

4. Complete Supervisor's Accident Investigation form.

5. Forward all of the above forms to the Central Office.

Central Office

1. Complete the Kansas Employer's Report of Accident form

2. File with the Kansas Department of Labor within time frame specified by law.

Kansas Association of School Boards
Supervisor's Accident Investigation Report

This report is to be completed by the injured person's supervisor before the end of the shift during which the accident or illness occurred.

NAME OF INJURED PERSON:_____

AGE: _____EMPLOYMENT STATUS FULL-TIME☐ PART-TIME☐ VOLUNTEER☐

DATE OF ACCIDENT:_____DAY OF ACCIDENT:_____TIME:_____A.M. / P.M.

DEPARTMENT:_____OCCUPATION:_____

HOURS INTO SHIFT WHEN OCCURRED:_____HOW LONG EMPLOYED?_____

EXACT LOCATION OF ACCIDENT:_____

WAS ACCIDENT SITE REVIEWED BY SUPERVISOR? Yes ☐ No ☐

DID SUPERVISOR INTERVIEW INJURED PERSON? Yes ☐ No ☐

DID SUPERVISOR INTERVIEW WITNESSES? Yes ☐ No ☐

EXACTLY HOW DID ACCIDENT OCCUR? DESCRIBE PERSONS, ACTION, EQUIPMENT, CONDITIONS, ETC.:

_____

_____

_____

WAS EMPLOYEE WEARING/USING REQUIRED SAFETY EQUIPMENT? Yes ☐ No ☐ N/A ☐

WHAT EQUIPMENT COULD HAVE BEEN UTILIZED TO PREVENT THIS ACCIDENT?

_____

_____

IS THIS EQUIPMENT AVAILABLE FOR EMPLOYEE USE? Yes ☐ No ☐

FOR EACH OF THE FOLLOWING FACTORS, INDICATE WHAT COULD BE IMPROVED TO PREVENT THIS ACCIDENT:

TRAINING

_____

_____

_____

COMMUNICATIONS

_____

_____

_____

POLICIES/PROCEDURES

_____

_____

_____

INSPECTIONS/OBSERVATIONS

_____

_____

_____

WHAT IMMEDIATE ACTION HAS BEEN TAKEN TO PREVENT THE RECURRENCE OF A SIMILAR ACCIDENT?

_____

REPORT BY INJURED EMPLOYEE ATTACHED? Yes ☐ No ☐

REPORTS OF EYEWITNESSES ATTACHED? Yes ☐ No ☐

WAS FIRST AID ADMINISTERED ON THE SCENE? Yes ☐ No ☐

WHO AUTHORIZED MEDICAL TREATMENT?_____

SUPERVISOR SIGNATURE:_____ DATE:_____

****

TO BE ROUTED TO:

****

TO BE FILLED OUT BY THE DEPARTMENT DIRECTOR

COMMENTS:_____

_____

_____

SIGNATURE_____ DATE_____

TO BE COMPLETED BY SAFETY COORDINATOR

COMMENTS:_____

_____

_____

SIGNATURE_____ DATE_____

TO BE COMPLETED BY SUPERINTENDENT

COMMENTS:_____

_____

_____

SIGNATURE_____ DATE_____

REPORT BY INJURED EMPLOYEE

Employer:_____

Your Name:_____

Your Home Address:_____

Your Home Phone Number:_____

Social Security Number:_____

Date of Accident:_____Time of Accident:_____

In your own words, please describe what happened:_____

_____

_____

_____

What physical problems do you relate to this injury?_____

_____

_____

Did you report this injury to your supervisor?_____If not, why not?_____

Date Reported?_____Supervisor's Name:_____

Were you working at your regular job at the time of the injury?_____If not, please explain:

_____

_____

_____

Were there any witnesses?_____If yes, who?_____

_____

Did you go to a hospital/clinic? Yes_____No_____

Address of hospital/clinic:_____

Name of treating physician:_____

Any additional comments:_____

_____

_____ _____

Date Signature