

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 (DHCP). 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.

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 (*CIRCLE ONE*): 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 COMPLETED BY SUPERINTENDENT or DESIGNEE

COMMENTS: _____

SIGNATURE

DATE

U.S.D. 481 EMPLOYEE ACCIDENT/INJURY REPORT

Your Name: _____

Your Position: _____

Date and Time of Injury: _____

In your own words, please describe what happened: _____

What problems do you relate to this injury? _____

Date Reported: _____

Supervisor's Name: _____

Were you working at your regular job at the time of the injury: Yes No
If no, please explain:

Were there any witnesses? Yes No If yes, who? _____

Any additional comments: _____

Date: _____

Employee signature: _____

U.S.D. 481 ACCIDENT/INJURY EYEWITNESS REPORT

Name of Injured Employee: _____

Name of Witness: _____

Address: _____

Telephone Number: _____

Date of Incident: _____

In your own words, describe what you saw happen: _____

Did anyone else see the accident? Yes No

If yes, please list their name(s)? _____

Other comments: _____

Signature of Eyewitness: _____