

**EAGLE MOUNTAIN- SAGINAW INDEPENDENT SCHOOL DISTRICT  
SUPERVISOR ACCIDENT INVESTIGATION FORM**

**INSTRUCTIONS:**

In an effort to provide and promote a safe working environment, the immediate supervisor of an employee injured on the job or experiencing an occupational exposure to blood (other than their own) or other potentially infectious material should investigate all injuries and file this report within **twenty-four (24) hours of the injury**. Immediate supervisors include central administrators, principals, directors, maintenance & custodial supervisors, head custodians, and cafeteria managers. PRINT all information requested on this form.

Please email the completed form to **Kimberly Heiskell, Coordinator of Risk Management: kheiskell@ems-isd.net**

Name:

Title:

Date report completed:

**EMPLOYEE ACCIDENT INFORMATION**

Injured Employee's Name: \_\_\_\_\_ Title: \_\_\_\_\_

Employee's Department or Campus: \_\_\_\_\_

Date of incident: \_\_\_\_\_ Time of incident: \_\_\_\_\_ AM/PM

Facility where incident occurred: \_\_\_\_\_

Location of incident (kitchen, classroom; self-contained/ACES, etc.): \_\_\_\_\_

When was the incident reported to you:

Date reported: \_\_\_\_\_ Time reported: \_\_\_\_\_ AM/PM

List all witnesses to the incident: \_\_\_\_\_

Was employee performing regular duties: YES or NO

Does the employee speak English: YES or NO

Did injured employee seek medical treatment from a doctor or nurse: YES or NO

If yes, please explain where:

List any protective equipment the employee was wearing when injured (back support belt, gloves, eye wear, etc.):

What injuries did the employee report (body part(s) affected, type of injury):

List any circumstances or conditions that you believe contributed to the accident:

What action has been taken to correct and/or eliminate any contributing factors:

What can be done to avoid a recurrence of this type of injury:

If the Employee or Witness is a NON-ENGLISH SPEAKER, please translate their statement of how the injury occurred from their form below:

☐ Translated for Employee \_\_\_\_\_ ☐ Translated for Witness \_\_\_\_\_

I hereby acknowledge that the above information is true and correct to the best of my knowledge.

Signature \_\_\_\_\_

Date \_\_\_\_\_

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Please email this completed form to Kimberly Heiskell, Coordinator of Risk Management: [kheiskell@ems-isd.net](mailto:kheiskell@ems-isd.net)