



Cumberland County Schools
Accident Investigation and Report of Injury Form
ALL SECTIONS MUST BE COMPLETED

EMPLOYEE MUST COMPLETE THESE SECTIONS:

EMPLOYEE DATA

Employee Name: _____ Employee ID or SSN : _____

Address: _____ Home Phone: _____

City/State/Zip: _____ Sex: M F DOB: _____

Department/School: _____ Work Phone: _____

Employee Work Hours/Start-End Time: _____

Job Title(s) ex. Bus/cafeteria: _____ Date of Hire: _____

Date of Injury/Illness: _____ Time of Injury/Illness: _____ am pm

Date employee reported injury: _____

Supervisor's Name: _____ Work Phone: _____

EMPLOYEE STATEMENT

Specific Injury/Illness/Exposure and Specific Body Part(s) Affected: _____

Location of Injury/Illness: _____

What equipment, materials, or chemicals caused the injury/illness? _____

Who witnessed the injury? _____ Phone #: _____

Explain in detail how injury occurred. Include specific activities/tasks performed at the time.

Medical treatment provided by: First Aid NextCare Urgent Care Fayetteville Ortho Other (specify)

Employee Signature: _____ Date: _____

SUPERVISOR MUST COMPLETE THESE SECTIONS:

SUPERVISOR'S INVESTIGATION & STATEMENT

After investigation, explain in detail how the injury/illness occurred and the specific activity being performed:

What was the injury, illness, or exposure? (be specific)

FINDINGS OF CAUSE (Must be completed by supervisor or designee**)**

- Struck by or against object Caught in/under/between Fall/Slip/Trip
- Material handling or lifting Repetitive Motion Chemical Exposure
- Bodily fluid exposure Animal Bite Human Bite
- Other (explain): _____

CONTRIBUTING FACTORS & ACTIVITIES (Must be completed by supervisor or designee**)**

Equipment:

- Equipment failure
- Equipment unavailable
- Improper equipment/material used

Personal Protective Equipment:

- Not worn
- Not readily available
- Not adequate for the task
- Personal protective equipment failure

Training/Experience:

- Lack of training
- Safety training provided, not followed
- Lack of experience or new task for employee

Work Area:

- Set up improperly
- Inadequate lighting/noise issues
- Housekeeping issues
- Environmental factors (rain,wind,temp.,etc)
- Ventilation issues
- Ergonomic factors

Employee:

- Physically not able to do work
- Employee fatigue
- Unbalanced or poor position/motion
- Incorrect procedures used for task
- Other unsafe practice

Assistance:

- Difficult to perform task w/o help
- Safety features or devices not readily available
- Assistive devices not used

Miscellaneous:

- Lack of policy/procedure
- Animal (explain): _____
- Other (explain): _____

RECOMMENDATIONS FOR CORRECTION (be specific)

PREVENTIVE ACTIONS TAKEN

Supervisor Will:

- Develop/revise safety procedures Request ergonomic evaluation
- Order new equipment Order new personal protective equipment
- Remove equipment from use and repair/replace Schedule preventive maintenance
- Will retrain employees before task is re-assigned Perform on-site review of work activity
- Reconfigure work area Communicate corrective actions to others in job category
- Recommendation for preventive action (****mandatory; explain in detail****):

Preventive actions will be completed by:

Name _____

Expected date of completion _____

Supervisor's Signature: _____ Date: _____

****Reference Policy 4201/7271****

Accident Witness Statement

(To be completed by accident witness)

Injured Employee's Name: _____

Name of Witness: _____

Job Title of Witness: _____

Location of Accident (be specific):

Date of Accident: _____ Time of Accident: _____

Describe fully how accident occurred:

Describe bodily injury sustained (be specific, ie: lft arm, rt middle finger, etc.):

Recommendation of how to prevent this accident from recurring:

Name of Supervisor: _____

Signature of Witness: _____ Date: _____