

NESHAMINY SCHOOL DISTRICT EMPLOYEE INCIDENT REPORT

Employee Information (Completed by the Employee - Please print)

Name: _____ Date of Birth: _____ Gender: () M () F
Position: _____ Status: FT PT Location: _____ Hire Date: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Marital Status: _____ # Dependents under 18: _____ Telephone: _____ SS# _____
Incident Date: _____ Incident Time: _____ (AM/PM) Location of Incident: _____
Normal Start Time: _____ (AM/PM) Describe how the incident occurred and resulting injury: _____

List any Equipment, machinery or contributing factors to the incident (Factual only – not opinion): _____

Did injury occur on employer premises? Yes No Did you return to work? Yes No

Identify Part(s) of Body Injured: _____

Indicate Type of Injury: Strain Contusion Laceration Burn Other _____

Did you seek medical treatment from a panel physician (reverse side): Yes No

If yes, indicate location : _____

List any witnesses: _____

I agree that the above is true, correct and complete and acknowledge that I understand the policies of my employer relative to the panel of physicians:

Employee Signature: _____ Date: _____

SUPERVISORY REPORT – (Please print)

Supervisor Name: _____ Dept/Location: _____

Did you witness the incident: Yes No Time/Date incident reported: _____

How did injury occur? (Activity engaged in/Tools or equipment used) _____

Was the incident result for an unsafe act on the part of the employee? Yes No By another? Yes No

Did the incident result from mechanical defect? Yes No Has preventative action been taken? Yes No

Describe Action taken to prevent future incidents: _____

Check factors contributing to incident/injury?

| | | |
|--|--|---|
| <input type="checkbox"/> Failure to comply with direction | <input type="checkbox"/> Improper Sharps Disposal/Transfer | <input type="checkbox"/> Equipment Malfunction |
| <input type="checkbox"/> Physically Assaultive Behavior | <input type="checkbox"/> Improper Use of Equipment | <input type="checkbox"/> Failure to Secure/Warn/Place Signs |
| <input type="checkbox"/> Hazardous Work Surface Conditions | <input type="checkbox"/> Improper Use of Hands/Body Parts | <input type="checkbox"/> Unsafe Posture or Position |
| <input type="checkbox"/> General Environmental Conditions | <input type="checkbox"/> Improper Body Mechanics for Task | <input type="checkbox"/> Gripping Objects Insecurely |
| <input type="checkbox"/> Operating/Working at Unsafe Speed | <input type="checkbox"/> Failure to Use Personal Protective Equip. | <input type="checkbox"/> Excess Weight Bearing |
| <input type="checkbox"/> Other (Please Describe): _____ | | |

Treatment: Panel Physician Emergency Room Declined Treatment Returned to Duty Other _____

Signature of Supervisor: _____ Telephone #: _____ Date: _____