Charleston CUSD #1

Employee Injury or Illness - FORM B

(This form to be completed for all Employee Injuries requiring treatment by a Physician)

Name of Employee who was injured: _____

Date of injury: _____
Time of day injury occurred: _____
Employee was scheduled to work from _____ to _____ on date of the injury.

Date of birth: _____
Date of employment: _____
Job title: _____
Length of time in present position: _____
Department: _____

Emergency contact information for employee: _____

Phone number for emergency contact: _____

Did the injury occur on school premises: ☐ Yes ☐ No
Please define specific location

Address of the accident: _____

Specific location on school premises where injury occurred: _____

_____

Please describe specifically what work employee was performing when the injury occurred: _____

_____

What is the specific injury (please also list the specific part of the body affected and describe how it was affected?

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Please define medical treatment employee received:

First Aid: ☐ Yes ☐ No

Person(s) providing First Aid _____

Physician: ☐ Yes ☐ No

Physician Name:

_____

Emergency Room: ☐ Yes ☐ No

Hospital Name: _____

Treating Physician: _____

What object or substance directly injured employee?_____

_____

Please describe in detail how the injury occurred: _____

_____

_____

_____

If injury occurred outside, please describe weather conditions at the time of the injury (Temperature, Rainy, Cloudy, Foggy, etc.): _____

_____

_____

Witnesses at the scene of accident: _____

_____

_____

_____

Witness Statements: (Ask each Witness to provide statements regarding the injury):

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Was the supervisor present at the time of the incident? ☐ Yes ☐ No

Any other employees involved in the injury: ☐ Yes ☐ No
If yes, name of employee: _____

What tool(s) or equipment was in use? _____

What personal protective equipment (PPE) or safety equipment was in use?

_____

_____

What instructions had been given? _____

_____

_____

By whom? _____

What object directly caused the injury? _____
How? _____

Who controlled the object or equipment that contributed? _____

_____

What unsafe act caused or contributed? _____

_____

How? _____

What unsafe condition caused or contributed? _____

_____

How? _____

Was ergonomics a cause or contributor? ☐ Yes ☐ No
If yes, how? _____

What district safety rules, procedures or OSHA rules or procedures were violated? _____

_____

_____

Was there anything that could have been done to prevent this accident / injury / incident? ☐ Yes ☐ No

If yes, _____

Did the Supervisor/Safety Committee review this incident? ☐ Yes ☐ No

What was recommended? _____

What corrective or follow-up action was taken? _____

_____

_____

When? _____

Was an all employee discussion of this accident conducted? ☐ Yes ☐ No

When? _____

Was this incident/accident investigated? ☐ Yes ☐ No

By whom? _____

Was the employee properly trained to do the job? ☐ Yes ☐ No

Has the employee had this accident/incident before? ☐ Yes ☐ No

When? _____

Is police report attached? ☐ Yes ☐ No

Sketches are complete: measurements, heights, angles, _____

Summary of accident _____

_____

_____

_____

Analysis of accident _____

_____

_____

_____

Employee's Signature _____ Date _____

Supervisor's Signature _____ Date _____

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