The Alliance

The Arizona School Alliance for Workers' Compensation, Inc.

Supervisor's Incident Report

Complete and submit this report to the district office within 24 hours from notice of accident.
Fatalities must be reported immediately.

EMPLOYEE INFO Name: _____ SS#: _____ Date of Birth: _____
Home Address: _____ City: _____ State: _____ Zip: _____ Home Phone: _____
District:_____
School/Dept: _____ Job Title: _____ Cell Phone: _____
Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Dependents: ☐ Yes ☐ No
Date of Hire: _____ Reg. Shift: From_____ ☐ AM ☐ PM To_____ ☐ AM ☐ PM Pre-employment Physical Completed : ☐ Yes ☐ No
Employment: ☐ Full-Time ☐ Part-Time ☐ Seasonal ☐ Intermittent Months: ☐ 10 ☐ 12 ☐ Other Wage: $_____ ☐ hr ☐ wk ☐ mth

ACCIDENT INFO Date of Injury/Illness: _____ Time of Event: _____ ☐ AM ☐ PM Fatality: ☐ YES ☐ NO
Location Description (i.e. parking lot): _____ Date Supervisor Notified: _____ On Site: ☐ Yes ☐ No
Accident Address (if not on premises): _____ City: _____ State: _____ Zip: _____
Employee Description of Accident:

Last Day of Work after Injury: _____ Date of Return to Work: _____ Still Off: ☐ Yes ☐ No Validity doubted: ☐ Yes ☐ No
Date of First Treatment: _____ Name of Clinic/ER/Hospital: _____ Phone: _____
Object or substance that harmed employee (i.e. student, hammer, etc): _____ What was employee doing just before incident (be specific): _____

ACCIDENT TYPE

- ☐ Strain/sprain
- ☐ Slip/Trip/Fall
- ☐ Hit by/Struck against
- ☐ Laceration/puncture
- ☐ Burn-heat/scald/shock
- ☐ Foreign body
- ☐ Chemical Exposure
- ☐ Repetitive Motion
- ☐ Needle Stick
- ☐ Vehicle Accident
- ☐ Assault
- ☐ Other_____

PART OF BODY ☐ **Left** ☐ **Right** ☐ **Both** ☐ **Other**

- ☐ Abdomen
- ☐ Ankle
- ☐ Arm
- ☐ Back
- ☐ Chest
- ☐ Ear
- ☐ Eye
- ☐ Face
- ☐ Finger
- ☐ Foot
- ☐ Groin
- ☐ Hand
- ☐ Head
- ☐ Knee
- ☐ Leg
- ☐ Shoulder
- ☐ Toe
- ☐ Wrist
- ☐ Other: _____ _____

INVESTIGATION ☐ Preventable ☐ Not preventable
Did another person not in company employ caused accident? ☐ Yes ☐ No
Name: _____ Address: _____ Phone: _____

Witness Name: _____ Witness Address: _____ Witness Phone: _____
Witness Statement, if any:

UNSAFE CONDITION

- ☐ Improperly guarded
- ☐ Safety devices inoperative
- ☐ Effective
- ☐ Hazardous arrangement
- ☐ Improper illumination
- ☐ Improper ventilation
- ☐ Lack of suitable PPE
- ☐ Unsafe dress or apparel
- ☐ Hazardous dust, gases or fumes
- ☐ Unclassified (give details): _____
- ☐ No unsafe condition

UNSAFE PERSONAL FACTORS

- ☐ Improper attitude
- ☐ Lack of required safety knowledge
- ☐ Defective eyesight
- ☐ Defective hearing
- ☐ Fatigue
- ☐ Muscular weakness
- ☐ Pre-existing heart weakness
- ☐ Pre-existing hernia
- ☐ Appears intoxicated
- ☐ Unclassified (give details) _____
- ☐ No unsafe personal factor

UNSAFE ACT

- ☐ Working/operating without authority
- ☐ Working on moving machinery
- ☐ Working on dangerous equipment
- ☐ Working at unsafe speeds
- ☐ Making safety devices inoperable
- ☐ Taking unsafe position or posture
- ☐ Handling materials incorrectly
- ☐ Working with overactive child
- ☐ Using defective tools
- ☐ Using hands instead of tools
- ☐ Unsafe loading or unloading
- ☐ Failure to use personal protective equipment
- ☐ Distracting, teasing, or horseplay
- ☐ Not following rules or instruction
- ☐ Unsafe decision
- ☐ Unclassified (give details) _____
- ☐ No unsafe condition

REQUIRED CORRECTIONS

- ☐ Pre-job training
- ☐ Retraining of all staff
- ☐ Improve illumination
- ☐ Improve ventilation
- ☐ Improve inspection process
- ☐ Improve clean-up process
- ☐ Improve enforcement
- ☐ Improve storage arrangement
- ☐ Eliminate congestion
- ☐ Revise job procedure
- ☐ Install/revise safety guards
- ☐ Require PPE
- ☐ Repair/replace equipment
- ☐ Require safer materials (explain)
- ☐ Improve design/construction
- ☐ Discipline employees involved
- ☐ Warn employees involved
- ☐ Reinstruct employees involved
- ☐ Job reassignment
- ☐ Other _____

PERSONS RESPONSIBLE FOR CORRECTION **COMPLETE DATE**
_____ _____
_____ _____
_____ _____

FOLLOW UP WITH EMPLOYEE Date: _____
Comments: _____
_____
_____

SUPERVISOR Name: _____ Phone: _____ Email: _____
Signature: _____ Date: _____
APPROVED BY Name: _____ Phone: _____ Email: _____
Signature: _____ Date: _____
Claim submitted to Alliance: ☐ Online ☐ Fax ☐ Mail Date submitted: _____

THIS FORM IS FOR DISTRICT USE ONLY. EMPLOYER'S REPORT OF INDUSTRIAL INJURY (101) MUST BE SUBMITTED ONLINE OR VIA FAX.