



VSBA Workers' Comp Group Supervisor's Incident Report

This form must be completed as soon after the accident as possible

Employee: _____ SSN: ____ - ____ - ____ Incident Date ____ / ____ / ____
 Address: _____ Date of Birth: ____ / ____ / ____ Phone No.: _____
 _____ District: _____
 City: _____ School: _____
 Occupation: _____

Describe what happened, in detail, body part affected and, if extremity involved, which side (right/left):

Employee Signature: _____ Date: _____

Disposition of the injured employee: Return to work Date _____ Doctor _____ Home Hospital

Age Group	Under 20	Type of Accident	Struck by	Nature of Injury	Amputation	Part of Body	Arm	Unsafe Condition	Guarding	Unsafe Act	Not authorized	Unsafe Personal Factor	Attitude												
	20-29		Strain		Contusion		Low Back		Safety inop		Fail to LOTO		Lack of trng												
	30-39		Laceration		Crush		Chest		Defect		Speed		Eyesight												
	40-49		Fall – level		Death		Elbow		Lighting		Unsafe position		Hearing												
50-59	Fall – Diff lvl	Electrocute	Ear	Ventilation	Bypass safety	Fatigue																			
Over 60	Strck agnst	Fracture	Finger	PPE	Imprpr tools	Stress																			
Time	____ PM	Type of Accident	Vehicle	Nature of Injury	Inhalation	Part of Body	Hand	Unsafe Condition	Apparel	Unsafe Act	Unsafe load	Unsafe Personal Factor	Drug/Alcohol												
	____ AM		Caught in		Hearing		Environment		Horseplay		Medication														
	Overtime		Burn		Foreign body		NOC		Rules		NOC														
	Day of Week S M T W T F Sa		Electrical		Cut		No unsafe		NOC		None														
Sex	Time on Job ____ yrs ____ mos	Type of Accident	Occ Disease	Nature of Injury	Multiple	Part of Body	Leg	Unsafe Condition	Unsafe Act	Unsafe Personal Factor	Unsafe Personal Factor	Unsafe Personal Factor	Unsafe Personal Factor												
	Male <input type="checkbox"/>		Misc		Sprain		Multiple							Neck											
OSHA Rcrdable Yes <input type="checkbox"/> No <input type="checkbox"/>	Fatal Lost time Dr. visit First aid	Type of Accident	Nature of Injury	Nature of Injury	Multiple	Part of Body	Multiple	Unsafe Condition	Unsafe Act	Unsafe Personal Factor	Unsafe Personal Factor	Unsafe Personal Factor	Unsafe Personal Factor												
														Female <input type="checkbox"/>	Nature of Injury	Nature of Injury	Multiple	Part of Body	Multiple	Unsafe Condition	Unsafe Act	Unsafe Personal Factor	Unsafe Personal Factor	Unsafe Personal Factor	Unsafe Personal Factor
Female <input type="checkbox"/>	Nature of Injury	Nature of Injury	Multiple	Part of Body	Multiple	Unsafe Condition	Unsafe Act	Unsafe Personal Factor	Unsafe Personal Factor	Unsafe Personal Factor	Unsafe Personal Factor	Unsafe Personal Factor													

Regular Job? Yes No Witness(es): _____

Report delayed? Yes No Why? _____

Describe any unsafe act or failure to act by employee(s) or others: _____

Describe any mechanical, physical, or environmental conditions that contributed to the incident: _____

Describe any personal factors that contributed to the incident: _____

What personal protective equipment **was being** used? _____ Was it effective? Yes No

What personal protective equipment **should** have been used? _____ Was it available? Yes No

Date of report: ____ / ____ / ____ Supervisor: _____ Title: _____