GRANITE FALLS SCHOOL DISTRICT #332

EMPLOYEE INCIDENT REPORT

If you have been injured on the job, you must complete this form and turn it into your immediate supervisor.

Employee Name: _____

Employment Location: _____

Date of Injury: _____ Time of Injury: _____

Describe in detail how the injury occurred: _____
_____
_____
_____
_____
_____
_____

Was this injury caused by failure of a machine or product OR someone who is not an employee? _☐_ Yes _☐_ No _☐_ Possibly

Part of body injured or exposed: _____
_____
_____

List any witnesses to your injury:
_____
_____
_____

Additional Comments or Information: _____

_____ _____
Employee Signature Date

_____ _____
Supervisors Signature Date

THIS FORM MUST BE TURNED INTO THE L & I ADMINISTRATOR AT THE DISTRICT OFFICE

GRANITE FALLS SCHOOL DISTRICT #332
SUPERVISOR'S REPORT OF INCIDENT

This form must be completed by the Supervisor within 24 hours of report of accident/illness by an employee.

Injured Employee Name:_____

Employment Location: _____

Date of Injury: _____ Time of Injury: _____

Was the injured worker performing regular duties: _☐_ Yes _☐_ No

If no, what was he/she doing at the time of injury?: _____
_____

Describe in detail how the injury occurred and if any contributing factors were involved?:
_____
_____

Was this injury caused by failure of a machine or product OR someone who is not an employee? _☐_ Yes _☐_ No _☐_ Possibly

Part of body injured or exposed: _____
_____

List any witnesses to your injury: _____
_____

Was emergency, medical or police contacted? _☐_ Yes _☐_ No

Action taken by emergency, medical or police?:_____
_____

Action taken to prevent a reoccurrence:_____
_____

Additional Comments or Information: _____
_____

_____ _____
Employee Signature Date

_____ _____
Supervisors Signature Date

THIS FORM MUST BE TURNED INTO THE L & I ADMINISTRATOR AT THE DISTRICT OFFICE