SUPERVISOR'S ACCIDENT REPORT OF INJURY

TOSHA OFFICE • Colville Confederated Tribes

PO Box 150, Nespelem, WA 99155
Phone: 509.634.2447 Fax: 509.634.2419

EMPLOYEE STATUS
❑Full Time
❑Part Time
❑Other

ACCIDENT CLASSIFICATION
❑ First Aid Only
❑ Medical Treatment

Date of Report _____

Please Complete ALL Information

1. Name: _____ Social Security # _____
2. Address _____ Home Phone: _____
3. Age: _____ Sex: _____ Occupation/Title: _____
4. Was Employee engaged in regular course of his duties at time of accidents? ❑ Yes ❑ No
5. If No, explain: _____
6. Experience at this work activity: _____ years _____ months _____ weeks
7. Total job experience for CCT? _____ years _____ months _____ weeks
8. Department _____ Date Reported to Supervisor _____
9. Date of Accident: _____ Time: _____ AM / PM Last Day Worked: _____
10. Location of Accident: _____
11. How many days/hrs per week is employee employed? _____
    If seasonal, give total weekly hours _____
    Regular Days Off _____
12. Shift Hours _____ AM / PM Rotating Shift _____
13. Employee Rate of Pay (No Overtime) $ _____ per ❑ Hour ❑ Week ❑ Month (check appropriate box)
14. Do you agree with the employee's description of the accident or information? If not, explain:

_____

Nature of Injury or Disease (cut, bruise, poisoning, etc.) _____

Part of Body Affected _____ ❑ Left ❑ Right

15. TYPE OF ACCIDENT (Circle one only)

1. Slip and/or fall - same level
2. Slip and/of fall - different level
3. Struck by falling/flying object
4. Contact with tools/knives/power equipment
5. Contact with/by temperature extremes
6. Contact with/by electrical current
7. Contact with/by liquid/gasNapor/etc.
8. Struck against
9. caught in, under, between
10. Exposure - disease, parasite
11. Over-exertion - lifting/pulling/pushing
12. Other _____

CAUSE OF ACCIDENT (Circle one only)

1. Inadequate guards or protection
2. Defective equipment/ tool/material substance
3. Congestion
4. Inadequate warning system
5. Fire and/or explosion
6. Substandard housekeeping
7. Hazardous atmospheric conditions
8. Excessive noise
9. Radiation exposure
10. Occupational illumina- tion/ventilation
11. Poor layout, planning, design
12. Sharp/rough/frayed/ cracked edges
13. Water/oil, etc. in walkway
14. Foreign object in walkway
15. Unexpected movement hazard
16. Ice/Snow
17. Operating without authority
18. Errors of others
19. Errors of employee
20. Improper prodecures
21. Horseplay
22. Other _____

16. What was job assignment at time of accident? _____
17. What caused this accident? (Explain in detail, use extra paper if needed) _____

_____

18. Corrective action taken to prevent future accidents of this kind _____

_____

19. Witness(es) (Attach their written statements) _____
20. Date Safety/Loss Control Manager contacted _____ If not contacted, why? _____

NOTE: ACCIDENT REPORTS MUST BE COMPLETELY FILLED OUT FOR EVERY ACCIDENT AND DELIVERED TO SAFETY/LOSS CONTROL OFFICE WITHIN TWENTY-FOUR (24) HOURS.

_____ Immediate Supervisor's Signature

_____ Safety/Loss Control Signature

White Copy - Safety/Loss Control, Yellow Copy - Supervisor, SEND WHITE COPY TO SAFETY/LOSS CONTROL