# Supervisor's Accident Report of Injury

Ph: (509)634-2842
Fax: (509) 634-2722

*Colville Confederated Tribes Human Resources Office P.O Box 150 Nespelem, WA 99155*

**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/her duties at time of accident? Yes No
5. If No, explain: _____
6. Experience doing the 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 hour _____ AM/PM _____ AM/PM Rotating shift: _____
13. Employee rate of pay (No overtime) $ _____ *per Hour Week Month (circle appropriate box)*
14. Do you agree with the employee's description of the accident or information? YES NO

If not explain: _____

Nature of injury or disease (cut, bruise, poisoning, etc.) _____

Part of body affected: _____ Left Right

15. Type of accident

1. Slip and/or fall - same level
2. Slip and/or 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

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 illumination/ventilation
11. Poor layout, planning, design
12. Sharp/rough/frayed/cracked edges
13. Water/oil, etc. in a 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 procedures
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 Human Resources office contacted _____ If not contacted, why? _____

***NOTE: Accident reports must be completely filled out for every accident and delivered to Human Resources office within 24 hours***

_____ Immediate supervisor's signature

_____ Human Resources WC Tech. signature

Revised 03/2014 JJS