EDUCATION
COOPERATIVE

SUPERVISOR'S REPORT OF ACCIDENT- INTAKE FORM

EMPLOYEE NAME____________________ SOCIAL SECURITY #______________
EMPLOYEE ADDRESS______________________________________
TELEPHONE NU:__HOME____________WORK________________
MARITAL STATUS________________DATE OF HIRE_______________
DEPARTMENT___________________OCCUPATION_________________
DATE OF BIRTH________ SEX(M or F)______AVERAGE WEEKLY WAGE________
NUMBER OF DEPENDENTS_________DATE OF INJURY________________
DESCRIPTION OF INJURY____
LOCATION ACCIDENT OCCURRED___________________________________
WITNESS _____________WITNESS ADDRESS___________________________
TELEPHONE NU:____________________
TO WHOM WAS INJURY REPORTED TO/THEIR POSITION_________________
DID EMPLOYEE LOSE TIME FROM WORK? (Y or N)_____
FIRST DAY OF DISABILITY _________ FIFTH DAY OF DISABILITY_________________
WAS MEDICAL TREATMENT SOUGHT?(Y or N)_____Tax ID Number:__________
MEDICAL FACILITY ____
DATE REPORTED A WORK RELATED:________INJURY:_______BODY PART:_____

RETURN TO WORK DATE:_____________________________________

*******Supervisor's Complete Below*********

DESCRIPTION OF ACCIDENT; WHAT WAS EMPLOYEE DOING? WHAT HAPPENED?WHY?____
____

CAUSE-UNSAFE ACT OR CONDITION; OBJECT/SUBSTANCE CAUSING INJURY
____
____
____

WAS EMPLOYEE WEARING SAFETY GEAR? YES_______NO_____(IF NO, EXPLAIN)
____
____

ACTION TAKEN TO PREVENT SIMILAR ACCIDENTS_________________________
REMARKS____
____
____
____

Investigated By_______________________________Date____________________
Reviewed By_________________________________Date____________________
☐ School Nurse ☐ Supervisor

An Interlocal Service of the Massachusetts Municipal Association