ISSAQUAH SCHOOL DISTRICT 411

Employee Incident/Accident Form

Must be completed within 48 hours of Incident/Accident

Revised 10/17/19

HR OFFICE USE ONLY/CLAIM # _____

EMPLOYEE SECTION

Name _____ Job Title _____ Bargaining Group _____

Work Hours (Start/Stop) _____ Site Incident/Accident Occurred _____

Date of Incident _____ Time of Incident _____ Date Reported to Supervisor _____

Describe the incident/accident:

Was there an injury? Yes No Body Part/s _____ Type of Injury _____

Did you see a doctor for this injury? Yes No

Treatment/action taken (complete even if no medical attention needed):

Were students involved? Yes No Name of Student(s) _____

In your opinion, could this incident have been prevented? Yes No

If yes, explain:

Employee Signature _____ Date _____

Sign and Give to Supervisor

SUPERVISOR SECTION - Return completed form to Sena Camarata, Director of HR within 72 hours of incident

Describe the event as reported to/witnessed by you:

Was there an injury? Yes No Do you agree with the injury as described above by the employee? Yes No

If no, please explain:

Was the incident/accident the result of an unsafe act or condition? Yes No

Was property damaged? Yes No Was personal protective gear needed? Yes No Was it used? Yes No

What resolution/s were taken to prevent future, similar incidents/accidents?

Other comments/information:

Supervisor Signature _____ Date _____