



Irvine Unified School District  
**CONFIDENTIAL - Do Not Copy**  
**SUPERVISOR'S ACCIDENT INVESTIGATION REPORT**

**EMPLOYEE INFORMATION** (To Be Completed )

Name of Injured \_\_\_\_\_

Job Classification \_\_\_\_\_ Work Location \_\_\_\_\_

Illness Hours Remaining \_\_\_\_\_ Vacation Hours Remaining \_\_\_\_\_

Supervisor \_\_\_\_\_ Contact Number \_\_\_\_\_

Signature of Supervisor \_\_\_\_\_ Date \_\_\_\_\_

**INJURY/ILLNESS INFORMATION** (To Be Completed )

Nature of Injury \_\_\_\_\_

Date Injury Occurred \_\_\_\_\_ Approximate Time \_\_\_\_\_

Date of Knowledge \_\_\_\_\_ Approximate Time \_\_\_\_\_

Is Employee Being Accommodated Within Their Job Classification? YES NO N/A

INCIDENT REPORT ONLY - Employee Did Not Seek Medical Treatment

**INVESTIGATION DETAILS** (To Be Completed )

Did the accident/illness occur while the employee was acting during the scope and course of their employment?  
YES NO

Was there an unsafe condition that caused the injury/illness? If applicable, attach a copy of the work order.  
YES NO

Did you visit the site of the accident/illness? YES NO

Witness (1) \_\_\_\_\_ Contact Number \_\_\_\_\_

Witness (2) \_\_\_\_\_ Contact Number \_\_\_\_\_

Witness (3) \_\_\_\_\_ Contact Number \_\_\_\_\_

Summarize your findings \_\_\_\_\_  
Attach Additional Sheets, if necessary

**FOR RISK MANAGEMENT USE ONLY**

Accepted _____	Delayed _____	_____
<input type="checkbox"/> Witness Statement(s)	<input type="checkbox"/> Lack of Medical Findings	Keenan SafeSchools Training
<input type="checkbox"/> Medical Findings	<input type="checkbox"/> Employer Level Investigation	_____
<input type="checkbox"/> Employer Level Investigation	<input type="checkbox"/> AOE/COE	District Health Benefit Information