

Andrews Independent School District

Supervisor's Injured Employee Investigation Form

Injured Employee: _____ **SSN#** _____

Location of Injury: _____

Work Classification: _____ **# Yrs Employ:** _____

Date of Injury: _____ **Time:** _____

Date Injury was reported: _____

Witnesses: _____

Describe the extent of the injury: _____

How did the injury occur? _____

What caused the accident? _____

Injured lost time from work? _____ **Yes** _____ **No** _____

Doctor's attention required? _____ **Yes** _____ **No** _____ **Doctor:** _____

Date of Doctor's appointment: _____

Has an accident similar to this happened before? _____ **Yes** _____ **No** _____

What could be done in order to prevent future accidents of this nature? _____

What action have you taken to prevent future accidents? _____

Supervisor's Signature

Date

***Send a copy of this report to the Insurance Dept. in the Business Office.**