

Northfield Mount Hermon School
ACCIDENT REPORT
PART A
(to be completed by employee)

Name of Injured:		Date of Accident:		
Home Address:		Social Security #: (optional)	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth:
Employee's Usual Occupation:		Occupation at Time of Accident:		
Supervisor/Department:		Date of Hire:		
Time in Present Job: <input type="checkbox"/> Less than 1 month <input type="checkbox"/> 1-5 months <input type="checkbox"/> 6 months to 5 years <input type="checkbox"/> more than 5 years		Employment Category: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Temporary <input type="checkbox"/> Academic Year <input type="checkbox"/> Calendar Year <input type="checkbox"/> Staff <input type="checkbox"/> Faculty		
Nature of Injury and Part of Body:		Names of Others Injured in Same Accident:		
Name and Address of Physician:		Name and Address of Hospital:		
Time of Injury:	Phase of Employee's Workday at time of Injury: <input type="checkbox"/> Performing Work Duties <input type="checkbox"/> Working Overtime <input type="checkbox"/> Entering or Leaving Plant <input type="checkbox"/> During Rest Period <input type="checkbox"/> During Meal Period <input type="checkbox"/> Other:	Location of Accident: On Employer's Premises? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Describe how accident occurred include events leading up to the injury. Be as specific as possible.				
Employee Signature:		Witnesses to Accident:		

ACCIDENT REPORT

PART B

(to be completed by supervisor)

Task and Activity at Time of Accident: A. General Type of Work: B. Specific Activity: C. Employee was working: <input type="checkbox"/> Alone <input type="checkbox"/> With crew or co-worker <input type="checkbox"/> Other, specify:	Posture of Employee: Supervision at Time of Accident: <input type="checkbox"/> Directly Supervised <input type="checkbox"/> Indirectly Supervised <input type="checkbox"/> Not Supervised <input type="checkbox"/> Supervision not feasible
Severity of Injury: <input type="checkbox"/> First Aid <input type="checkbox"/> Medical Treatment <input type="checkbox"/> Lost workdays <input type="checkbox"/> Restricted workdays <input type="checkbox"/> Fatality <input type="checkbox"/> Other, specify:	
Causal Factors. Events and conditions that contributed to the accident.	
Corrective Actions. Those that have been, or will be, taken to prevent recurrence.	
Investigation Notes:	
Prepared by: (Supervisor)	Reviewed by:
Supervisor:	HR:
Department Head:	Safety: