Rainier School District

INCIDENT/ACCIDENT REPORT

NOTE: Use this form ONLY if a Worker's Comp Form (801) is not filed

To Be Completed by Employee:

Name of Employee: _____Building: _____

Address: _____Department:_____

Date of Incident: _____ Hour: _____AM PM Regular Shift:_____

Detailed Description of Incident: _____

_____

_____

Name of Witnesses: 1)_____ 2)_____

To whom has incident been reported: _____

Date reported to above person (s):_____

Have you seen a doctor? ____yes; ____ No; If YES, who and when: _____

_____

Did you fill out a Worker's Comp form (801)? ____ Yes ____ No

Signature of Employee: _____ Date Signed:_____

To Be Completed by Principal/Supervisor/Administrator:

Name of Principal/Supervisor/Administrator: _____

Date Incident reported to above:_____

Description of Incident as reported:_____

_____

_____

What were the existing conditions: _____

_____

Personal Defects – General observations (attitude, lack of knowledge or skill, physical deficiency, etc.): _____

_____

Background – Are there contributing factors other than job related?

_____

Signature of Principal/Supervisor/Administrator: _____

Date Signed:_____

Please send original form to District Office