Clackamas Education Service District
Human Resources Office
Ph: 503-675-4014 · 503-675-4067
Fax: 503-675-4200
Email: hr@clackesd.org

Accident Analysis | Incident Report Form

When you have an on-the-job injury, you MUST NOTIFY your supervisor IMMEDIATELY. With your supervisor you will complete this form and send it to the Human Resources office. Contact the Human Resources Office if a supervisor is not available. If unsure whether staff need medical treatment or may self-administer first aid, use Providence's Express Virtual Care.

All questions must be answered and filled in!

Date and Time:			
Employee Name:		Manager Name:	
Employment Category:	☐ Classified ☐ Licensed ☐ Manager ☐ Confidential ☐ Substitute/Temporary/Other		
Department: (Check ONLY one)	☐ LEEP ☐ Heron Creek ☐ EI/ECSE ☐ Printing ☐ Teaching & Learning (*formerly CIE*) ☐ Head Start to Success ☐ CCR&R ☐ Tech Services (NIS) ☐ Other (Other, Fiscal, HR, Supt)		
Accident Location: (Check ONLY one)	☐ Classroom/School ☐ Community Facility ☐ Client Residence ☐ Sunnybrook ☐ Other: _____		
Location Name:			
Injured part of body:	☐ Upper Extremities ☐ Lower Extremities ☐ Head ☐ Neck ☐ Trunk (Back/Torso) ☐ Multiple Body Parts		
Nature:	☐ Contusion/Bruise ☐ Strain/Sprain ☐ Cut/Laceration/Scrape/Puncture ☐ Fracture ☐ Contagious Disease (e.g bite, scratch, spitting incident) ☐ Other: _____		
Cause:	☐ Struck or Injured By Student/Person ☐ Bite ☐ Fall/Slip or Trip ☐ Strain/Sprain ☐ Motor Vehicle ☐ Other: _____		
Personal Protective Equipment Worn:	☐ Sleeves ☐ Jacket ☐ Face Guard (Masks/Safety Glasses) ☐ Shin Guards ☐ Gloves ☐ Protective Mats ☐ Hearing Protection / Ear Plugs ☐ None Worn ☐ Not Applicable ☐ Other: _____		

***** Have you accessed Providence's Express Virtual Care? Get real-time advice from a nurse on how to best treat injury (https://virtual.providence.org) *****

Describe illness or injury:

What caused injury? What were you doing?

Describe first aid rendered/staff response:

What will be done to prevent this type of accident in the future? Goal – AVOID REPEAT

	PERSON(S) RESPONSIBLE	TARGET DATE

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____