EAST MILLINOCKET SCHOOL DEPARTMENT
45 North Street, East Millinocket, ME 04430
207-746-3500 (ph) * 207-746-3516 (fx)

SUPERVISOR'S INCIDENT REPORT

This report should be completed within 24 hours of the incident while the facts are still fresh in the minds of witnesses and should be filed with the department responsible for the processing of Workers' Compensation claims.

Name of injured employee ____

Occupation when injured ______________________________ School ______________________

Was employee performing regular occupation? __________ If not, what occupation? ______________

Was employee experienced/trained in this occupation? _________ Secondary Employment? ___________

Date of injury ___________ Hour of day __________ AM _____ PM _____

Describe the events which resulted in the injury or disease

____

____

____

Primary Cause of Injury

____

Action taken to prevent recurrence ______________________________________

Describe the injury /disease and indicate body parts affected (specify **(L) or (R) side**) ______________

Do you have any questions or concerns pertaining to this injury? Yes ________ No ________

If "yes," please explain ____

Are you aware of any pre-existing or contributory injuries/conditions? ______________________

Name(s) of any witnesses ____

Was medical treatment provided? ________ Medical provider ____________________________

Were you notified by the injured employee of this injury? ________ If so, when? ________________

Did employee lose any time from work? ____________ If so, when did disability start? _____________

Has employee returned to work? ___________ When? _________________________________

Light Duty ________ Regular Duty ________ Number of Hours ________ Rate of Pay ________

Light Duty work available? ________

______________________ ______________________________
Date Signature

______________________ ______________________________
Phone number (Position and Department)