MAINE SCHOOL MANAGEMENT ASSOCIATION
INSURANCE PROGRAMS
49 Community Drive, Augusta, ME 04330
Telephone: (207) 626-5450 W/C Fax: (207) 620-7090
Website: *www.msmaweb.com*

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? Doctor _____

Hospital _____

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 _____

Any Light Duty work available? _____

_____ _____

Date Signature

_____ _____

Phone number (Position and Department)