

MARGARETTA LOCAL SCHOOLS

SUPERVISOR'S INVESTIGATION REPORT

Employee Name: _____ **Date of Injury:** _____ **OSHA Log #** _____

OSHA 301 Info in Bold

Was the employee killed as a result of the accident? If yes, indicate date of death: _____ Yes No

Were there any witnesses to this injury?

If yes, witness statements should be attached.

Was the injury a result of horseplay, under the influence of drugs, or purposely self-inflicted? Yes No

If yes, please specify details on the back of this form or on another page.

Has there been any recent disciplinary action taken against this employee? Yes No

If so, please describe:

Has the employee submitted medical documentation for the injury? If so, please attach. Yes No

Was the employee treated in an emergency room or similar? Yes No

Was the employee hospitalized overnight as an in-patient? Yes No

If known, please provide us with the name, address and telephone number of attending physician and/or

hospital:

Physician: _____

Facility: _____

Has the employee returned to work? Yes No
Last Day worked _____ Returned to work _____

Does the employee have restrictions to duty? Yes No **Applicable dates:** _____

Is the employee performing their full duties? Yes No

Was the employee given a prescription by the physician? Yes No

Employee Date of hire: _____

Have the conditions that caused the accident been controlled? Yes No

Describe action taken to prevent the accident in the future: _____

With the information you have, would you recommend the claim be accepted? Yes No

If no, why? _____

Completed by:

Supervisor Signature/Title/Phone

Date

Workers' Compensation Coordinator Signature

Date

**Please attach completed incident reports, witness statements and any accumulated medical bills and information. Additional comments may be noted on the reverse side.