MOORE COUNTY SCHOOLS
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Supervisor Report of Accident Form (Rev 10/43123)

*This form is to be completed by a Principal/Supervisor within 24 to 48 hours of the accident

Submit this form to the bookkeeper after completing. The bookkeeper will forward to: Janet Tate, jantate@ncmcs.org (classified employees) or Tina White tiwhite@ncmcs.org. (certified employees) Approved workers' compensation. facilities require an "Authorization Form." Bookkeepers are to contact Janet or Keshia before sending an employee to a doctor's office or facility. Sending employees to an unauthorized doctor or facility may cause a claim to be denied. (Refer to https://www.ncmcs.org/cms/One.aspx?portalId=19566378&pageId=21517356 for approved facilities.)

1. Employee Name: ____ Date of Report:____________ Employee Phone #:______________________________

   Employee Address:____

   City:____ State: NC Zip Code: _____________ Work Location___________________________

   Occupation: ___________________________________ Work Hours: Begin:___________End:___________

   Date of Accident:_____________________ Time of Accident:_______________a.m./p.m. Exact Location:____

   Description of the Accident: ____

   ____

   What was the employee doing?:____

   What tools or equipment was being used? ____

____

2. Describe the extent of employee's injury, be specific (ex. cut on right foot, bruise on left leg, etc.): ____

____

____

3. Witnesses – First and Last Name/What they saw or heard and when **(Must include a written statement from each witness):** _______________________

____

____

   Date the employee reported the accident?: _________________________ Tim the employee reported the accident::______________________________

   Did the employee go to a doctor for treatment? Yes or No ____

   Doctor's Name & Facility Name: ____

   Facility Address & Facility Phone Number?____

   Did the employee go to the hospital or Urgent Care facility? Yes or No Which one? ____

   Does the employee plan to seek medical treatment? Yes or No Where? ____

   Did the employee return to work after the accident? Yes or No Date returned to work?__________________Time returned to work?_____________

Supervisor or Designee to complete:

4. Principal/Supervisor: Do you question the validity of this claim? Yes or No If yes, why? ____

____

5. After investigating this accident, was this caused by an unsafe act or unsafe condition? ____

____

____

6.. What should be done, and by whom, to prevent this accident from recurring? ____

____

____

7. What are you doing to ensure this is done? ____

____

____

(REQUIRED: Principal/Dept. Director MUST sign form.)

Supervisor's Signature:____ Date: ____

*Principal/Dept.Director:____ Date: ____

Office Use Only

Carrier_____________ Claim#________________________ Location____________ LINQ__________ Case #______________