



MAINE SCHOOL MANAGEMENT ASSOCIATION

49 Community Drive, Augusta, Maine 04330-9405

in the State of Maine 1-800-660-8484

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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)