WAPPINGERS CENTRAL SCHOOL DISTRICT
Supervisor's Investigation & Report of Incident

Name of Injured (Last, First, M.I.):	Social Security #:	Date of Birth:	Sex: M / F
Mailing Address of Injured:	City/State/Zip:	Phone #:	
Work Location:	Job Title:		

WHEN:	Date & Time of Incident: / / : AM / PM	
	Date Reported to Supervisor: / /	
	If Delayed, Why?	
DESCRIPTION OF INCIDENT:	Detail what employee was doing and/or what physical objects and/or materials were involved:	
	Was employee doing something other than required duties? YES / NO If yes, explain:	
WHAT:	State body parts that were injured:	
	Was treatment beyond first aid required? YES / NO If yes, explain	
	Fatality? YES / NO	Lost Time? YES / NO
WHERE:	Exact location of where incident occurred:	
	Was ambulance transport necessary? YES / NO To which facility:	
WITNESSES:	(Last Name, First Name / Title / Phone #):	
WHY:	Comment on the causes of the incident:	

Is there reason to believe that this claim should be investigated? YES / NO

SUPERVISOR/MANAGER:

Print Name: _____

Title: _____ Phone #: _____

Signature: _____ Date: _____

Please return this form to sandra.strack@wcsdny.org