Troup County School System
SUPERVISOR'S INCIDENT REPORT

EMPLOYEE
Address _____ Soc. Sec. # _____
City, State & Zip _____ Phone _____
Job Title _____ Department _____

INCIDENT DATA
Place of Occurrence _____ Time of Occurrence _____
Exact Location _____
Date Reported _____ Reported To _____

Did the employee return to work? Y_____ N_____ Unknown_____ If yes, date _____

Brief description of the injury/illness (burn, fracture, strain, etc) _____

Body part(s) affected (right hand, left foot, etc) _____

Witness _____ Witness _____

Treatment provided by Doctor/Emergency Room _____ School Nurse _____
Supervisor _____ Other _____ Specify _____

SUPERVISOR'S COMMENTS

Describe clearly what occurred (how, what, where, when, etc.)

_____
_____
_____

In your opinion, what act/failure to act or condition(s) contributed most directly to this happening?

_____
_____
_____

What actions have been or will be taken to prevent recurrence?

_____
_____
_____

_____
Supervisor Date

_____
Administrator Date

NOTE: This form must be forwarded to the Central Office within 48 hours of the incident.