ALAMO COLLEGES DISTRICT

ENTERPRISE RISK MANAGEMENT

Email completed form to:

ERM	**dst-ERM@alamo.edu**	
Jennifer Wilgen	**jwilgen4@alamo.edu**	**210-485-0069**
Mike Legg	**mlegg2@alamo.edu**	**830-237-9934**

☐ DIST ☐ SAC ☐ SPC ☐ SWC ☐ PAC ☐ NVC ☐ NLC ☐ Other:_____

SUPERVISOR INJURY REPORT

NAME OF INJURED EMPLOYEE:	BANNER ID OF EMPLOYEE:	DATE OF INJURY: TIME OF INJURY: ☐AM ☐PM
DEPARTMENT:	☐MALE ☐FEMALE	DATE REPORTED TO SUPERVISOR: TIME REPORTED TO SUPERVISOR: ☐AM ☐PM
NATURE OF INJURY:	PART OF BODY INJURED:	
CAUSE OF INJURY:	LOCATION OF ACCIDENT:	
JOB ACTIVITY BEING PERFORMED AT TIME OF ACCIDENT:	NAME AND PHONE # OF WITNESS(ES):	

WAS EMPLOYEE ACTING WITHIN THE COURSE & SCOPE OF JOB DUTIES AT THE TIME OF THE INJURY? ☐YES ☐NO

BRIEF DESCRIPTION OF ACCIDENT:

DESCRIBE HAZARD CONTROLS/WARNING SIGNS IN THE AREA:

DESCRIBE UNSAFE PHYSICAL OR MECHANICAL CONDITION, IF ANY:

WHAT DID THE EMPLOYEE **DO OR FAIL TO DO** THAT CONTRIBUTED TO THE ACCIDENT?

PERSONAL EQUIPMENT BEING USED AT TIME OF ACCIDENT: (GLOVES, SAFETY GLASSES, GOGGLES, FACE SHIELD, OTHER):

COULD THIS INJURY HAVE BEEN PREVENTED? ☐YES ☐NO IF YES, PLEASE EXPLAIN:

WHAT ACTIONS WILL BE TAKEN TO PREVENT FUTURE ACCIDENTS?

DO YOU AGREE WITH EMPLOYEE'S DESCRIPTION OF THE ACCIDENT OR INFORMATION? IF NOT, PLEASE EXPLAIN.

TYPE OF INJURY: CHECK BOX THAT APPLIES

- ☐ SLIP/FALL – INDOORS SAME SURFACE
- ☐ SLIP/FALL – OUTDOORS SAME SURFACE
- ☐ SLIP/FALL – INDOORS ELEVATED SURFACE
- ☐ SLIP/FALL – OUTDOORS ELEVATED SURFACE
- ☐ STRUCK BY FALLING/FLYING OBJECT
- ☐ STRUCK AGAINST OBJECT
- ☐ CONTACT WITH TEMPERATURE EXTREMES
- ☐ MOTOR VECH. ACCIDENT
- ☐ CONTACT WITH GAS OR CHEMICAL
- ☐ CONTACT WITH ELECTRICAL CURRENT
- ☐ CONTACT WITH EQUIPMENT
- ☐ CAUGHT IN/BETWEEN
- ☐ EXPOSURE DISEASE
- ☐ LIFTING, PUSHING OR PULLING
- ☐ OTHER

CAUSE OF INJURY: CHECK BOX THAT APPLIES

- ☐ INADEQUATE GUARDS OR PROTECTION
- ☐ DEFECTIVE EQUIPMENT OR MATERIALS
- ☐ INADEQUATE WARNING SYSTEMS
- ☐ FIRE AND/OR EXPLOSION
- ☐ LACK OF HOUSEKEEPING
- ☐ HAZARDOUS ATMOSPHERIC CONDITIONS
- ☐ EXCESSIVE NOISE
- ☐ INADEQUATE LIGHTING
- ☐ POOR LAYOUT/PLANNING/DESIGN
- ☐ OTHER
- ☐ SHARP/ROUGH/UNFINISHED SURFACE
- ☐ FOREIGN SUBSTANCE IN WALKWAY
- ☐ UNEXPECTED MOVEMENT HAZARD
- ☐ UNAUTHORIZED OPERATION
- ☐ IMPROPER PROCEDURES
- ☐ ERRORS OF OTHERS
- ☐ ERRORS OF EMPLOYEE
- ☐ HORSEPLAY
- ☐ INATTENTION

WAS 911 CALLED? ☐YES ☐NO	**WAS INJURED EMPLOYEE TRANSPORTED BY EMS?** ☐YES ☐NO
SUPERVISOR'S PRINTED NAME:	**SUPERVISOR'S PHONE #:**
SUPERVISOR'S SIGNATURE:	**DATE:**

TO REQUEST MEDICAL CARE UNDER ALAMO COLLEGES' SELF-FUNDED WORKERS' COMPENSATION PROGRAM OR FOR QUESTIONS REGARDING THIS REPORT, PLEASE CALL ENTERPRISE RISK MANAGEMENT (ERM) AT THE #S LISTED ABOVE. THE COMPLETED FORM MUST BE PROVIDED TO ERM WITHIN 24 HRS. OF THE ACCIDENT. ALSO PROVIDE A COPY TO THE HEAD OF THE DEPARTMENT.

REVISED 07/26/2022