

EMPLOYEE ACCIDENT REPORT

COMPLETE THIS FORM AND SUBMIT TO SUPERVISOR OR SCHOOL NURSE WITHIN 24 HOURS OF THE ACCIDENT

NAME: _____ DATE OF BIRTH: _____ SS # _____
(FIRST, MIDDLE, LAST)

MALE FEMALE ADDRESS: _____ PHONE # (____) _____

OCCUPATION: _____ DATE OF HIRE: _____ SALARY: _____

EMPLOYEE'S SUPERVISOR: _____

DO YOU HAVE ANY SECONDARY EMPLOYMENT: YES NO PLEASE LIST: _____

DATE OF ACCIDENT: _____ TIME OF ACCIDENT: _____ LOCATION OF ACCIDENT: _____

LIST ANY WITNESS PRESENT AT TIME OF ACCIDENT: _____

DESCRIPTION OF ACCIDENT (INCLUDE ACITIVITY, EQUIPMENT INVOLVED, CONTRIBUTING FACTORS): _____

TYPE OF INJURY SUSTAINED (SPRAIN, LACERATION, BRUISE, FRACTURE, **SPECIFY LEFT/RIGHT** ETC.): _____

DO YOU HAVE ANY PRE-EXISTIING HEALTH CONDITIONS OR INJURIES? YES NO PLEASE LIST: _____

DESCRIBE FIRST AID GIVEN: _____

TIME FIRST AID GIVEN: _____ BY WHOM: _____

WERE YOU SEEN BY THE SCHOOL NURSE: YES NO

EMPLOYEE SENT: HOME _____ PHYSICIAN _____ HOSPITAL _____ RESUMED WORK ACTIVITY _____

TRANSPORTED BY: AUTO _____ AMBULANCE _____ N/A _____

DATE FIRST SEEN BY MEDICAL PROVIDER IF APPLICABLE: _____

NAME AND ADDRESS OF MEDICAL PROVIDER: _____

DATE & TIME INJURY WAS REPORTED TO SUPERVISOR OR SCHOOL NURSE: _____

NAME OF SUPERVISOR OR SCHOOL NURSE TO WHOM YOU REPORTED THE ACCIDENT: _____

EMPLOYEE SIGNATURE _____ **DATE:** _____

SUPERVISOR OR SCHOOL NURSE SIGNATURE _____ DATE: _____

ADDITIONAL COMMENTS/FOLLOW-UP INFORMATION: _____
