PAWNEE CUSD #11

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 ACTIVITY, EQUIPMENT INVOLVED, CONTRIBUTING FACTORS):_____

_____

_____

TYPE OF INJURY SUSTAINED (SPRAIN, LACERATION, BRUISE, FRACTURE, CONCUSSION, ETC.):_____

_____

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

_____

DESCRIBE FIRST AID GIVEN:_____

_____

TIME FIRST AIDE GIVEN:_____BY WHOM:_____

WERE YOU SEEN BY THE SCHOOL NURSE: YES ☐ NO ☐

EMPLOYEE SENT: *HOME*_____ *PHYSICIAN*_ *HOSTPITAL*_____ *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'S SIGNATURE:_____DATE:_____

ADDITIONAL COMMENTS/FOLLOW-UP INFORMATION:_____

_____