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:

EMPLOEE’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: