

Employee Accident/Injury Report

(To be completed by Principal/Supervisor within 24 hours of time of accident/injury)

**Please note that filing this report is only the first step in the process. The District will contact you to schedule one, if not several, follow-up meetings as a part of its investigation into your accident/injury.*

EMPLOYEE INFORMATION (Please print legibly)	
Employee Name (Last, First, Middle initial)	
Employee Address	City State Zip
Home Telephone Number ()	Work Telephone Number ()
ACCIDENT INFORMATION	
Building or Site Where Accident Occurred (include address if not at a district facility)	
Date of Accident/Injury	Time of Accident/Injury Name of Person Notified
Describe how the Accident/Injury Occurred:	Body Part(s) Injured:
	Wrist _____ Hand _____
	Leg _____ Knee _____
	Head _____ Eye _____
	Face _____ Teeth _____
	Ankle _____ Foot _____
	_____ Chest _____
	Arm _____ Back _____
Neck _____ Other _____	
Please describe any resulting injury:	

TREATMENT INFORMATION

Did the Employee See a Doctor or Go to the Hospital? Yes No	Date of First Treatment (if known)
Name of Physician, Clinic or Hospital Name and City/Address	
Signature of Principal and/or Supervisor	Date
<i>Please FAX or deliver front page to the District Office <u>within 24 hours</u> of the Accident/Injury.</i>	

Part 2: Accident/Injury Follow-up and Investigation

Were there any witnesses to this accident?	Yes	No
--	-----	----

If Yes, complete the following:

Name of Witness(es)	Address	Telephone
---------------------	---------	-----------

Please answer the following questions. Circle "Yes" or "No". Indicate N/A if the questions does not apply.

- | | | |
|---|-----|----|
| 1. Was injured person properly instructed in safe efficient methods? | Yes | No |
| 2. Did he/she violate any instructions, policies or procedures? | Yes | No |
| 3. Was necessary protective equipment worn? (Goggles, safety belt, hard hat, etc) | Yes | No |
| 4. Did poor housekeeping contribute to the accident? | Yes | No |
| 5. Was accident caused by something which needed repair? | Yes | No |
| 6. Was accident caused by an unsafe act? | Yes | No |

What do you consider the cause(s) of this accident?

What steps are being taken to prevent similar accidents?

Lost Time Information

(If applicable)

Time Missed from Work:	Date Returned to Work:
------------------------	------------------------

Hours: Days:

Person Making Report:

Name	Title	Date
------	-------	------

Building

Principal/Supervisor Signature	Date
--------------------------------	------

Business Manager/Payroll & Benefits Review:

Send completed Employee Accident/Injury Report to Business Office within 3 work days.