BLOOMINGTON PUBLIC SCHOOLS, DISTRICT 87

EMPLOYEE ACCIDENT/INJURY REPORT FORM

All District employees are required to use this form to report any accident or injury incurred at work or on District property immediately (within 24 hours of the accident/injury) to their immediate supervisor. In addition, employees must contact the workers compensation administrator in the District office (extension 1001).

Your ***Name***: _____

Your ***Job Title***: _____

Date & Time of Accident/Injury**:** _____

Building & Location of Accident/Injury**:** _____

Were you at work at the time of the accident/injury, and ***what were you doing when it occurred*****:** _____

_____

_____

Describe the accident/injury and how it occurred**:** _____

_____

_____

Describe any ***injury*** to yourself or your property, including what ***part of the body was affected and how it was affected:*** _____

_____

Describe ***any object or substance*** that was involved and caused harm to you: _____

_____

What ***medical treatment*** did you receive and ***by whom***?

Immediately at the scene: _____

_____

Later at a medical facility: _____

_____

Name and Address of attending ***Physician***: _____

_____

List ***any witnesses*** to the accident/injury: _____

_____

Other Pertinent Information: _____

_____

Employee signature: _____

Person & Date form received by: _____

10/31/18