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