

EMPLOYEE ACCIDENT REPORT FORM

To be completed and signed by employee and person receiving report

SUBMIT DIRECTLY TO KATHY DAVIS at the DISTRICT OFFICE

GENERAL INFORMATION		
Employee Name: (Last, First, and Middle Initial)		Home Phone Number:
Home Address:		
Social Security #:	Date of Birth:	Employment Date:
Job Title:	Department:	Sex (M/F):
ACCIDENT INFORMATION		
Date of Accident:	Time of Accident: <i>a.m. / p.m.</i>	Where Did Accident Happen:
Detailed Description of What Happened:		
Specifically What You Were Doing, (in detail):		
Describe <u>Precisely</u> the Pain You Felt (sharp, dull), and Noise Heard (snap, pop, pull, sharp, from waist to knee, etc.):		
<u>Specific</u> Location of Pain (low back, right knee, etc.):		
Nature of Injury (bruise, twist, cut, scratch broke skin?, etc.):		
Did Accident Involve an Unsafe Act? Describe:		
Did Accident Involve an Unsafe Condition? Describe:		
How Could Accident Have Been Prevented?		
Medical Treatment? Name of Dr, Hospital, etc.		
Did Accident Involve a District Policy? Describe:		
Names of Witnesses:		
Employee Signature:		
Date Reported:	Date Received by Office:	Received By: