St. Joseph PUBLIC SCHOOLS

EMPLOYEE ACCIDENT / INJURY REPORT
EMPLOYEE MUST TAKE A COPY OF THIS FORM TO ANY DR. APPOINTMENTS

INJURED EMPLOYEE INFORMATION

Employee _____ **SS#** _____

Home Address _____

City _____ **State** _____ **Zip** _____

Sex Male Female **Date of Birth** _____ **Marital Status** _____

Position _____ **Building** _____

INJURY INFORMATION

Date of Injury _____ **Time of Injury** AM _____ PM _____

Where did the injury occur (Building/Location)?

Was the employee engaged in job duties at the time of the accident? Yes No

What is the nature of the injury? Please be specific. EXAMPLE: *Cut left wrist or cut and twisted left index finger*

Describe in DETAIL how injury occurred. Please be specific. EXAMPLE: *Caught left heel in crack on floor or while moving tables in classroom fell on left knee and hit right hand against door*

Witnesses *(if any):* _____

Was first aid given in fiel? Yes No **If Yes, by Whom?** _____

If Yes, Describe First Aid Given: _____

I DID NOT SEEK MEDICAL ATTENTION FOR THIS INJURY
If medical treatment is sought at a later date for this injury, you must notify Megan Dongvillo at Central Office (3111) immediately to authorize treatment.

I DID SEEK MEDICAL ATTENTION FOR THIS INJURY
By contacting the Business Office to schedule an appointment with the District's approved medical facility.

EXTREME EMERGENCY REQUIRING TREATMENT AT THE NEAREST EMERGENCY CENTER

Signature of Employee _____ **Date** _____

Signature of Supervisor _____ **Date** _____

Completed By (if not employee) _____ **Title** _____ **Date** _____

THIS FORM MUST BE COMPLETED AND RETURNED TO THE BUSINESS OFFICE WITHIN 48 HOURS OF ACCIDENT/INJURY