GERMANTOWN SCHOOL DISTRICT

Employee Accident Report

IMPORTANT

Please fill in immediately, and fax (253-3581) this form to or call: Human Resources at 253-3915. Send the original, signed by your supervisor, to Human Resources in the interoffice mail.

Injured Employee Information:

First/Middle/Last Name:

Social Security #:

Home Street Address:

City/State/Zip:

Home Telephone #:

Date of Birth:

Date of Hire:

Work Telephone #:

Sex:

Job Title:

Injured Employee Information:

Place of Accident (Building/School)

Address of Accident

Date of Injury:

Time of Injury:

Time Work Began on Day of Injury :

Date Employer Notified of Injury

Number of Hours usually Worked:

Per Week:

Per day:

Name of Person Notified:

Description of Accident/Illness: (Describe the injury fully, indicate area of pain or limitation, if any, and any objective evidence supporting same)

Describe, in detail how accident occured (what you were doing at time of injury)

What body part was injured?

Why did this accident/illness occur?

What aid was given after injury? By whom?

Did this injury occur at work?

Name (s) of witness

Did/will you seek medical treatment?

If yes, provide doctor, clinic, or hospital and city?

Was any work time lost because of accident?

If yes, last day worked:

Have you filed a claim related to this injury before?

If yes, explain

Any pre-existing condition that may of caused injury?

If yes, explain

Injured Employee Signature:

Date:

Supervisors Signature:

Date:

Report prepared by:

Date:

For Human Resources Only

Reported to WC on: ______________

By: ______________________