WALLED LAKE CONSOLIDATED SCHOOL DISTRICT
EMPLOYEE ACCIDENT REPORT

EMPLOYEE DATA:

Injured Employee Name _____ Birthdate _____

Address _____ City _____ Zip _____

Social Security Number _____ Home Phone _____

Dependents _____ Sex _____ Occupation _____

ALLEGED INJURY DATA:

Date of Injury _____ Time of Injury _____ Place of Injury _____
(school bus, playground, classroom, etc.)

Nature of injury and body part directly affected.

_____

_____

What was the employee doing when the injury occurred? Be specific.

_____

_____

Witness Name(s) (if any) _____

Will employee miss any work time? Yes☐ No☐ If yes, how many days? _____

MEDICAL TREATMENT:

Name of Medical Facility or Dr. _____

Address _____ Phone # _____

SIGNATURES:

_____ _____ _____
Supervisor Signature Building Date

I believe the above report is true and accurate.

OR

I do not wish to have medical treatment for the above injury at this time.

_____ _____

Employee Signature Employee Signature

4/98