DEERFIELD COMMUNITY SCHOOL DISTRICT

EMPLOYEE ACCIDENT REPORT FORM

To be completed and signed by employee then turned into the building secretary or direct supervisor, and then routed to Human Resources.

GENERAL INFORMATION:

Employee Name ____ Phone Number ___________________

Address ____ City, State, Zip ____________________________

Position ______________________________________ Work Location___________________________________

Hire Date __________________________ Date of Birth ____

ACCIDENT INFORMATION:

Date of Accident _____________ Time of Accident ___________ Location of Accident ____________________

Detailed description of what happened ____

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Specifically what were you doing ____

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Describe precisely the pain you felt (sharp, dull) and noise heard (snap, pop, pull, sharp, from waist to knee, etc.)

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Specific location of pain (lower back, right knee, etc.) ____

Nature of injury (bruise, twist, cut, scratch, broken 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 Doctor, Hospital, etc. ____

Did accident involve a District policy? Describe ____

Name(s) of Witnesses ____

EMPLOYEE MUST ALSO CALL ACUITY NURSE HELPLINE – 800-200-6375 IN ADDITION TO COMPLETING FORM

Employee Signature ______________________________________ Printed Name _________________________

Date Reported _______________ Date Received ___________________ Received by ______________________