EMPLOYEE INFORMATION (Please print legibly)			
Employee Name (Last, First, Middle initial)			
Employee Address	City	State	Zip
Home Telephone Number ( )	Work Telephone Number ( )		

ACCIDENT INFORMATION

Building or Site Where Accident Occurred (include address if not at a district facility)	
Date of Accident/Injury Time of Accident/Injury Name of Person Notified	
Describe how the Accident/Injury Occurred:	Body Part(s) Injured: Wrist _____ Hand _____ Leg _____ Knee _____ Head _____ Eye _____ Face _____ Teeth _____ Ankle _____ Foot _____ _____ Chest _____ Arm _____ Back _____ Neck _____ Other _____
Please describe any resulting injury:	

TREATMENT INFORMATION

Did the Employee See a Doctor or Go to the Hospital? Yes No	Date of First Treatment (if known)
Name of Physician, Clinic or Hospital Name and City/Address	
Signature of Principal and/or Supervisor	Date
Please FAX or deliver front page to the District Office <u>within 24 hours</u> of the Accident/Injury.	

Part 2: Accident/Injury Follow-up and Investigation		
Were there any witnesses to this accident?	Yes	No
If Yes, complete the following: Name of Witness(es)	Address	Telephone
Please answer the following questions. Circle "Yes" or "No". Indicate *N/A* if the questions does not apply.		
1. Was injured person properly instructed in safe efficient methods?	Yes	No
2. Did he/she violate any instructions, policies or procedures?	Yes	No
3. Was necessary protective equipment worn? (Goggles, safety belt, hard hat, etc)	Yes	No
4. Did poor housekeeping contribute to the accident?	Yes	No
5. Was accident caused by something which needed repair?	Yes	No
6. Was accident caused by an unsafe act?	Yes	No
What do you consider the cause(s) of this accident?		
What steps are being taken to prevent similar accidents?		
Lost Time Information (If applicable)		
Time Missed from Work Hours: Days:	Date Returned to Work:	
Person Making Report:		
Name	Title	Date
Building		
Principal/Supervisor Signature		Date