

Prairie Central C.U.S.D. #8
Employee Accident/Injury Investigation Report

Employee Name: _____

Employee's Information:

DOB: _____ SS#: __XXX-XX-_____ Home Phone #: _____

Address: _____

Job Title: _____ Date of Hire: _____

Accident Information:

Date of Accident/Injury: _____ Time: _____ Location: _____

Time employee began work on date of incident: _____ AM PM

Witness(es): _____

Description of accident/injury: _____

Nature and extent of injury: _____

How was the injury treated (first aide, EMS, hospital, etc.)? _____

Was a physician or specialist seen for the injury? Yes _____ No _____

Physician's Name: _____

Physician's Address: _____

Did employee go to Emergency Room? Yes _____ No _____

Did employee miss time from work due to injury – other than the day of the incident?

Yes _____ No _____ If so, how many days? _____

Supervisor's Signature: _____ Date: _____

**** Accident report must be filled out immediately for every employee accident and submitted to the Unit Office within two (2) days of the accident. ****