SAN ANGELO INDEPENDENT SCHOOL DISTRICT
EMPLOYEE ACCIDENT AND INJURY REPORT

Print or Type ***Report Only:_____***

Employee ID#_____ ***Seeking Medical Attention:_____***

Employee Name_____ Sex Male ☐ Female ☐ Birthday_____
Last First MI Month Day Year

Mailing Address_____ Home Telephone #_____
Street City Zip Code

Social Security #_____Date of Hire_____ Occupation of Injured Worker_____
Month Day Year

Marital Status Married ☐ Divorced ☐ Time Employee am☐ Time of am☐
Single ☐ Separated ☐ Number of Dependents_____ Began Work_____ pm☐ Injury _____pm☐

Date of Injury_____ Lost Time Began_____ Was it a full day? Yes ☐ No ☐
Month Day Year Month Day Year

If Time Lost: Date of *Return* to Work_____ – Or – *Expected* Date of Return to Work_____
Month Day Year Month Day Year

Supervisor's Name_____Supervisor's Phone #_____

Date Reported_____ Time Reported_____ am☐ pm☐
Month Day Year

Type of Injury/Illness_____ Object, tool, or cause of injury_____
(strain, sprain, cut, burn, foreign object in eye, bite, etc.) (slip, trip, fall, vehicle, falling object, etc.)

Specific Body Part Affected _____ Equipment, chemicals, or materials being used_____
(right, left, upper, lower, back, leg, knee, arm, shoulder, hand, finger, head, etc.)

Location of Injury_____
(campus, department, or other site) (stairs, classroom, cafeteria, kitchen, dock, hallway, parking lot, etc.)

Describe fully how accident occurred_____

_____

_____

_____

_____

Were safeguards or safety equipment provided? Yes ☐ No ☐ Were these safeguards or safety equipment used? Yes ☐☐ No ☐

Treating Facility/Doctor *(only if medical attention was required)*_____

Doctor's Address_____

Witness(es)_____ _____

_____ _____

For Personnel Department Use Only

Last Paycheck: Date_____ Amount_____ Bi-Weekly ☐ Monthly ☐

Rate of Pay: Hourly_____ Weekly_____

Report Only	☐	Employee's Signature Sheet	☐	Employee Rights	☐
Lost Time Claim	☐	TWCC-6	☐	Leave Offset	☐
Record Injury	☐	FMLA Notice	☐	Claims Log	☐
Wage Statement	☐	Supervisor's Report	☐		

SUPERVISOR'S INVESTIGATION OF ACCIDENT

Print or Type

Was the employee performing his/her regular job at the time of the injury? □ yes □ no

Had the employee been instructed regarding hazards of the job? □ yes □ no

UNSAFE CONDITIONS/ACTS:

What was unsafe concerning the machine, tool, equipment, premises, or vehicle?_____

_____

_____

_____

Why did the unsafe condition exist?_____

_____

_____

_____

What did anyone do or fail to do that led to this accident?_____

_____

_____

_____

ACTION(S) FOR PREVENTING SIMILAR ACCIDENT:

What action has been or should be taken to prevent a similar accident?_____

_____

_____

_____

_____

_____

Printed Name of Supervisor Signature of Supervisor Date

_____

Printed Name of Employee Signature of Employee Date