Renton SCHOOL DISTRICT
SERVICE | EXCELLENCE | EQUITY

Human Resources

ON-THE-JOB-INJURY REPORT

EMPLOYEE'S REPORT (This report is to be completed with your supervisor immediately following an accident. Original must be returned to Human Resources.)

Employee ___________________ Work Location________________ Work Phone _____

Position _______________ Shift Hours_____________ Supervisor __________________

Date of Accident_________ Time of Accident ________ Place of Accident _____________

Describe the accident (Give complete details and what you were doing when injury occurred) ____

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Where were you taken after the accident________________ By whom ______________

Description of injury ____

____

Projected return to work date _______________ Total work days lost_________________

Attending Physician _____________ Address _______________ Phone______________

Nature of treatment ____

Have you filed for Workers' Compensation? ________ (If yes, take the "Provider's Initial Report" to the attending physician and file the "Self-Insurer Accident Report (SIF-2)" immediately.)

Witness(es):

Name ______________________ Work Location________________ Work Phone _____

Name ______________________ Work Location________________ Work Phone _____

My signature authorizes Renton School District to contact my physician concerning injury resulting from this reported accident. Any time missed from work requires a "Return to Work" authorization from my physician.

Employee Signature_______________________________________ Date ____________