Report by Injured USD 250 Employee

This form must be completed and turned in to Lita Biggs, Director of Business Operations within 5 days of the actual injury.

Your Name:________________________________ Your Building Assignment:__________________________

Your Home Address:____

Your Home Phone Number:_____________________ Your Cell Phone Number:___________________________

Your Email Address:____

Date of Accident:__________________________ Time of Accident/Injury:________ a.m/ p.m

Location of Accident:____

Exactly how did accident occur? Describe persons, action, equipment, conditions, etc._________________________

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What physical problems do you relate to this injury? **Be specific** (include left or right, lower or upper etc).

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Did you report this injury to your supervisor?__________ If not, why not?____________________________

Supervisor's Name:_________________________________ Date Reported:_______________________________

Were you working at your regular job at the time of the injury?_______ If not, please explain?________________

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Were there any witnesses?__________ If yes, who?____

Did you go to a hospital/clinic? Yes_____ No_____ If not, why not?_____________________________

Name/Address of hospital/clinic:____

Name of treating physician:____

Any additional comments:____

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_________________________ ____
Date Signature

Modified 03.23.16 – Accident Fund Insurance Company