

**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
Month Day Year pm

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,
(right, left, upper, lower, back, leg, knee, arm, shoulder, hand, finger, head, etc.) or materials being used _____

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 Received

Rate of Pay: Hourly _____ Monthly _____ DOI Wage _____

- | | | |
|--|---|--|
| Report Only <input type="checkbox"/> | Employee's Signature Sheet <input type="checkbox"/> | Employee Rights <input type="checkbox"/> |
| Lost Time Claim <input type="checkbox"/> | TWCC-6 <input type="checkbox"/> | Leave Offset <input type="checkbox"/> |
| Record Injury <input type="checkbox"/> | FMLA Notice <input type="checkbox"/> | Claims Log <input type="checkbox"/> |
| Wage Statement <input type="checkbox"/> | Supervisor's Report <input type="checkbox"/> | |

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