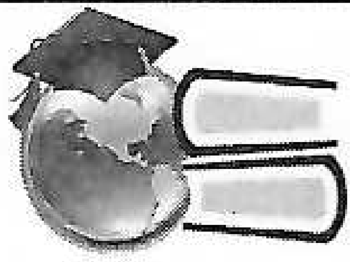

Selma City Schools

EMPLOYEE ACCIDENT REPORT FORM

PRINT OR TYPE

EMPLOYER

1. EMPLOYER'S NAME AND MAILING ADDRESS (No. & Street, City, County, State, ZIP)	LOCATION, IF DIFFERENT FROM MAILING ADDRESS
SELMA CITY SCHOOLS **2194 Broad Street** **P.O. Box 350** **Selma, AL 36702-0350** **TELEPHONE NUMBER (334) 874-1600**	

2. CARRIER OR SELF-INSURANCE REGISTRATION NUMBER

ALABAMA RISK MANAGEMENT FOR SCHOOL 191-10

EMPLOYEE

3. NATURE OF BUSINESS (Manufacturing, Trade, Transportation, etc.)	SPECIFIC PRODUCTS

4. EMPLOYEE'S NAME (Last) (First) (Middle)	5. SEX MALE [ ] FEMALE [ ]	6. AGE	7. SOCIAL SECURITY NO.

8. EMPLOYEE'S HOME ADDRESS (No. & Street or RFD, City, County, State, ZIP)	9. MARITAL STATUS: SINGLE [ ] MARRIED [ ] DIVORCED [ ] SEPARATED [ ] WINDOWED [ ]

INJURY OR ILLNESS

10. HOME TELEPHONE	11. REGULAR OCCUPATION	12. WORKING IN WHAT DEPARTMENT WHEN HURT

13. PLACE OF ACCIDENT OR EXPOSURE (Address or location, include County)	14. ON EMPLOYER'S PREMISES? YES [ ] NO [ ]

15. DATE OF OCCURRENCE	16. TIME OF DAY AM [ ] PM [ ]	17. Date Disability Began	18. Date Employer Notified

19. DESCRIBE THE INJURY OR ILLNESS IN DETAIL AND INDICATE THE PART OF THE BODY AFFECTED.
(E.g., amputation of right index finger at second joint, fracture of 2 ribs, lead poisoning, dermatitis of left hand, etc.)

20. IF FATAL, GIVE DATE OF DEATH

21. WHAT DIRECTLY PRODUCED THIS INJURY OR ILLNESS?
(Name object struck against or struck by; vapor, poison, chemical or radiation: if strain or hernia, the thing being lifted, pulled pushed etc.; if injury resulted solely from bodily motion, the stretching, twisting, etc. which resulted in injury.)

22. HOW DID THE ACCIDENT OR EXPOSURE OCCUR?
(Begin by telling what the employee was doing just before the accident or exposure. Be specific. If employee was using tools or equipment, or handling material, name them and tell what employee was doing with them.).

(Now describe fully the events which resulted in injury or illness. Tell what happened and how it happened. Specify how objects or substances were involved. Give full details of all factors which led or contributed to the accident or exposure.)

23. NAME AND ADDRESS OF TREATING PRACTITIONER	NAME AND ADDRESS OF HOSPITAL HOSPITALIZED [ ] OUT-PATIENT [ ] EMERGENCY [ ] TREATMENT [ ]

WAGE INFORMATION

24. Has Injured Returned to work? Yes [ ] No [ ]	25. If so, Date	26. At What Wage	27. At What Occupation?

28. LENGTH OF TIME IN YOUR EMPLOY?	29. LENGTH OF TIME IN PRESENT JOB	30. NUMBER OF DEPENDENTS

31. Average Weekly Wage	32. Weekly Value of Remuneration Other than Wages (Food, Lodging, etc.)	33. DID EMPLOYEE RECEIVE FULL PAY FOR THE DAY OF INJURY Yes [ ] No [ ]

34. Date of This Report	35. Signed By	36. Signature	37. Official Position or Title

White - Employee   Yellow - Principal   Pink - Health Services