FERNDALE SCHOOL DISTRICT #502
EMPLOYEE ACCIDENT REPORT

Employee Name (Last, First)		Address		Phone Number
Job/Position Title		School/Location		
Date of Incident	Time Shift Started	Supervisor Name		
Date of Birth	Time of Incident AM / PM	Date Time Loss Began	Total Work Days Lost	
Date Injury Reported	Time Injury Reported	Name of person to whom injury was reported		

What are your injuries? Describe the part of the body that was affected:

What happened? Explain how the injury occurred. What were you doing just before the accident occurred?

Names of any witnesses:

Did you seek medical attention? _____ If yes, date & time:

Physician and hospital:

Is this an original injury or a re-injury?

If a re-injury, when and where did previous injury occur?

What could have been done to avoid this incident?

Employee Signature	Date

Please complete and return this form to your Supervisor. The Supervisor is to review this form and complete the Supervisor's Report of Injury form and send both forms to the Business Office within 24 hours of the accident.