Addison Central School District
Employee Accident Report

This form is to be completed the same day of the injury, if possible, and forwarded to Gail Leach in the ACSD Central Office (Fax: 388-0024)

EMPLOYEE INFORMATION

Name: ____ Occupation/Job Title: ___________________________________

Male ___ Female ___ Birthdate: _____________ Age: _________ SS#: ______________________

Home Address: ____

Home Phone: _______________________ Marital Status: ___________________ Hire Date: ___________________

ACCIDENT INFORMATION

Date of injury: _________________ Time of injury: ________________ Date report made: _________________

Date employer notified: ___________ Who was notified: ____

DESCRIPTION OF INJURY (type, part of body injured, what was worker doing, equipment involved, etc.)

Employee start work time: ____________ Employee end work time: ___________ County of accident: _______________

Did accident occur on employer's premises? __________ If no, where did it occur: _________________________________

How could accident been prevented ____

Was safety equipment provided? __________________ Was safety equipment used? ___________________________________

Was there a witness? ________________ Witness name: ________________ Witness phone: ___________________

Did employee lose time from work? __________ Date last worked: ____________ Return to work date: _________________

NOTE: Please let Gail Leach in the ACSD payroll office know of time missed from work due to this injury.

EMPLOYER INFORMATION:

Employer: Addison Central School District

Address: 49 Charles Avenue
Middlebury, VT 05753

Phone: 802-382-1274 FAX: 802-388-0024

Location (School): ___________________________________

Address: ___________________________________
____

Phone: ___________________________________

Federal Tax ID# 81-4257106 Nature of Business: Public School

Insurance Carrier: VSBIT

State fund? NO Self-Insurance? NO

TREATMENT:

Was treatment (other than first aid) required at the time of injury? ________ If yes, please list name, address, and phone number of physician and/or hospital:

NOTE: If medical attention is not required at the time of the injury but required at a later date, please let Gail Leach in the ACSD payroll office know as soon as possible.

____ ____________________
Employee Signature Date

____ ____________________
Administrator's Signature Date