

**Employee Accident Report – Fill Out Completely**

Please forward to Kelly Dekoski at the administration building

Social Security No.: \_\_\_\_\_ Date of Injury: \_\_\_\_\_ Time: \_\_\_\_\_ Time you began work: \_\_\_\_\_

Name: \_\_\_\_\_ Street Address, City, State, Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Gender: Male ( ) Female ( ) Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Job Title: \_\_\_\_\_ Name of Building: \_\_\_\_\_ Date Hired: \_\_\_\_\_

Place of Accident: School Building ( ) School Grounds ( ) To or from School ( ) Home ( ) Other \_\_\_\_\_

|                         |                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                |
|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Nature of Injury</b> | Abrasion _____ Concussion _____ Puncture _____<br>Amputation _____ Cut _____ Scalds _____<br>Asphyxiation _____ Dislocation _____ Scratches _____<br>Bite _____ Fracture _____ Shock _____<br>Bruise _____ Laceration _____ Sprain _____<br>Burn _____ Poisoning _____ Strain _____<br>Illness _____ Other (specify) _____                                  | <b>DESCRIPTION</b><br>What was the employee doing before the incident occurred? _____<br>_____<br>What happened? _____<br>_____<br>_____                                                       |
|                         | <b>Part of Body Injured</b><br>(indicated left or right where applicable)<br>Abdomen _____ Eye _____ Leg _____<br>Ankle _____ Face _____ Mouth _____<br>Arm _____ Finger _____ Nose _____<br>Back _____ Foot _____ Scalp _____<br>Chest _____ Hand _____ Tooth _____<br>Ear _____ Head _____ Wrist _____<br>Elbow _____ Knee _____<br>Other (specify) _____ | What was the injury or illness? _____<br>_____<br>What object or substance directly harmed the employee? _____<br>_____<br>If the employee died, when did death occur? _____<br>_____<br>_____ |

Degree of Injury: No disability ( ) Temporary Disability ( ) Permanent Impairment ( ) Death ( )  
 Did you stop work as a result of your accident? \_\_\_\_\_ When? \_\_\_\_\_ Last day worked? \_\_\_\_\_  
 If not working, when do you expect to return to work? \_\_\_\_\_ If you did return, list the date? \_\_\_\_\_

|                               |                                                                                                                                    |                                          |
|-------------------------------|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|
| <b>Immediate Action Taken</b> | (Treatment provider is: Genesys Occupational Health Network, G-3121 S. Dort Hwy., Suite A, Flint, MI 48507 unless otherwise noted) |                                          |
|                               | Treatment not necessary _____                                                                                                      |                                          |
|                               | First-aid treatment received _____                                                                                                 | by (name): _____                         |
|                               | Sent to occupational clinic _____                                                                                                  | by (name): _____ located at: _____       |
|                               | Sent to after-hours clinic _____                                                                                                   | by (name): _____ located at: _____       |
|                               | Sent to emergency care _____                                                                                                       | by (name): _____ name of facility: _____ |
|                               | Names of witnesses: _____                                                                                                          |                                          |

|                 |                      |                       |                                                                                                                         |
|-----------------|----------------------|-----------------------|-------------------------------------------------------------------------------------------------------------------------|
| <b>Location</b> | Specify Activity     | Specify Activity      | What recommendations do you have for preventing other accidents of this type? _____<br>_____<br>_____<br>_____<br>_____ |
|                 | Athletic field _____ | Pool _____            |                                                                                                                         |
|                 | Auditorium _____     | Sch. Grounds _____    |                                                                                                                         |
|                 | Cafeteria _____      | Showers _____         |                                                                                                                         |
|                 | Classroom _____      | Stairs _____          |                                                                                                                         |
|                 | Corridor _____       | Supply room _____     |                                                                                                                         |
|                 | Gymnasium _____      | Toilet room _____     |                                                                                                                         |
|                 | Locker room _____    | Other (specify) _____ |                                                                                                                         |

**Employee Signature:** (fill out completely & obtain supervisor's signature)**Supervisor Signature:**

Date

Date