

Report by Injured USD 250 Employee

This form must be completed and turned in to Melissa Pennington, Director of Business Operations within 5 days of the actual injury.

Your Name: _____ Your Building Assignment: _____

Your Home Address: _____

Your Home Phone Number: _____ Your Cell Phone Number: _____

Your Email Address: _____

Date of Accident: _____ Time of Accident/Injury: _____ a.m/ p.m

Location of Accident: _____

Exactly how did accident occur? Describe persons, action, equipment, conditions, etc. _____

What physical problems do you relate to this injury? **Be specific** (include left or right, lower or upper etc).

Did you report this injury to your supervisor? _____ If not, why not? _____

Supervisor's Name: _____ Date Reported: _____

Were you working at your regular job at the time of the injury? _____ If not, please explain? _____

Were there any witnesses? _____ If yes, who? _____

Did you go to a hospital/clinic? Yes _____ **No** _____ **If not, why not?** _____

Name/Address of hospital/clinic: _____

Name of treating physician: _____

Any additional comments: _____

_____ Date

_____ Signature