

**BERLIN SCHOOL DISTRICT
BOYLSTON SCHOOL DISTRICT
BERLIN-BOYLSTON SCHOOL DISTRICT**

**EMPLOYEE ACCIDENT REPORT
MUST BE COMPLETED WITHIN 24 HOURS OF ACCIDENT**

PART I: INJURED EMPLOYEE STATEMENT

EMPLOYEE NAME: _____

SCHOOL: _____ **DEPARTMENT:** _____ **SEX:(M or F):** _____

DATE/TIME OF ACCIDENT: _____ **LOCATION ACCIDENT OCCURRED:** _____

NATURE OF INJURY: _____

DESCRIPTION OF ACCIDENT: _____

WAS THIS ACCIDENT RELATED TO ANY HAZARDOUS CONDITION OR EQUIPMENT? _____

DID ANYONE OBSERVE THIS ACCIDENT? (Y or N): _____

NAME (S) OF WITNESSES TO ACTUAL INJURY: _____

SIGNATURE of EMPLOYEE

Date of this report

PART 11: NURSE'S REPORT (IF INDICATED):

State visible signs of Injury: _____

Action Taken: _____

Employee sent to: _____
(Name and address of doctor and/or hospital)

(Signature of Nurse)

(Date)

WHITE: SUPERINTENDENT OF SCHOOL
GOLD: SCHOOL NURSE
YELLOW: PERSONNEL OFFICE