Report of Accident

Complete in black ink only

GENERAL INFORMATION

Name:	Social Security (required):	Campus/Department:	Occupation:
Employee number:	Street Address:		
City:	State:	Zip Code:	Cell Phone:
Date of Birth:	Sex: M F	Status: ☐Married ☐Single ☐Widowed ☐Divorced ☐Separated	
Number of Dependent Children:	Spouse's Name:		

Office Use Only:
DOH: _____ Daily Base Rate: _____
Campus/Dept. #: _____
Campus/Dept. Name _____ Hrs. Work Per Day: _____
Occupation: _____

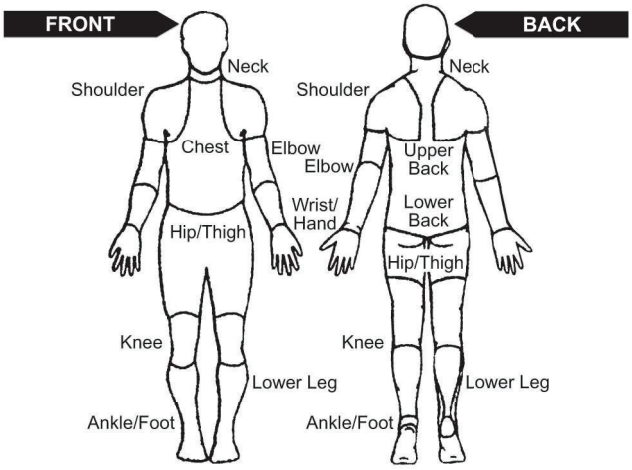
ACCIDENT INFORMATION (Must be completed by injured employee)

Date of Accident: | Location (i.e., hallway, cafeteria, etc): | Time: ☐am ☐pm

In your own words, describe in detail the incident that led to your injury.

Witnesses Names:

Shade in all the areas of discomfort on the figure.



Using the scale below, rate the discomfort for both the left and right side of the body area named in the box at right.

No Discomfort Area **Worst Discomfort**

1 2 3 4 5 6 7 8 9 10

Discomfort Area	Right	Left
Neck		
Shoulder		
Chest		
Elbow/Forearm		
Hand/Wrist		
Hip/Thigh		
Knee		
Lower Leg		
Ankle/Foot		
Other		
Total		

Have you ever injured these body parts before (please indicate date, body part, and treating physician below)?

Date:	Body Part:	Treating Physician:
Date:	Body Part:	Treating Physician:

Medical Statement

Waiving Medical Attention: I am not seeking treatment at this time. I understand that if medical attention becomes necessary, I will email leave@pfisd.net to request to be seen.

Employee Initials: _____

Required Signatures

I hereby certify that the information above is true and correct to the best of my knowledge. I further understand that any falsification of information regarding an on-the-job injury or illness may result in disciplinary action up to and including termination of employment.

Employee's Signature: Date:

Campus Designee/Supervisor Signature (Required): Date:

Email this completed form to leave@pfisd.net to seek medical attention