WILLIS INDEPENDENT SCHOOL DISTRICT
ACCIDENT REPORT

Once completed and signed, please email to mdaniels@willisisd.org *for processing.*

TODAY'S DATE:	DATE INCIDENT WAS REPORTED:
FACILITY NAME:	CAMPUS/DEPT:
SUPERVISOR:	SUPERVISOR PHONE#:

NAME OF INJURED EMPLOYEE:	FEMALE ☐ MALE ☐
HOME ADDRESS:	
PHONE NUMBER	DATE OF BIRTH:
SOCIAL SECURITY #:	
DATE OF INCIDENT:	TIME OF INCIDENT:
DID THE INJURY OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO	
LENGTH OF SERVICE: YEARS MONTHS	
JOB TASK AT THE TIME OF ACCIDENT:	
EMPLOYEE WAS WORKING: ☐ ALONE ☐ WITH CO-WORKERS	
EMPLOYEE CATERGORY : ☐ REGULAR FULL TIME ☐ REGULAR PART TIME ☐ SEASONAL ☐ TEMP	
WAS THERE A WITNESS TO THE ACCIDENT? ☐ YES ☐ NO	
IF YES, PLEASE LIST THE NAMES OF WITNESSES:	

PART OF BODY INJURES:	☐ LEFT SIDE	☐ RIGHT SIDE

☐ SKULL/SCALP	☐ JAW	☐ ABDOMEN	☐ WRIST	☐ KNEE	☐ FOOT
☐ EYE	☐ NECK	☐ BACK	☐ HAND	☐ THIGH	☐ TOE
☐ NOSE	☐ SPINE	☐ PELVIS	☐ FINGER	☐ LOWER LEG	☐ ANKLE
☐ MOUTH	☐ CHEST	☐ SHOULDER	☐ HIP		
OTHER:					

NATURE OF INJURY:	☐ PUNCTURE	☐ MUSCLE STRAIN	☐ LACERATION
	☐ INSECT/ANIMAL BITE		FOREIGN BODY
OTHER:			

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EMPLOYEE DESCRIPTION OF ACCIDENT (ATTACH SHEET FOR ADDITIONAL INFORMATION):

PLEASE INITIAL IF YOU RECEIVED THE WILLIS ISD INJURED PACKAGE
DID EMPLOYEE GO TO A DOCTOR/HOSPITAL: ☐ YES ☐ NO

SIGNATURE OF EMPLOYEE:	DATE:
SIGNATURE OF SUPERVISOR:	DATE:
SIGNATURE OF SAFETY COORDINATOR:	DATE: