Report by Injured USD 250 Employee

This form must be completed and turned in to McGee Stoller, HR Leader, 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

_____

Printed Name

Revised: 9/24/2024