HERTFORD COUNTY PUBLIC SCHOOLS
REPORT OF ACCIDENT/INJURY/ILLNESS

(Must be completed immediately after the incident/accident or initial treatment **(NOT LATER THAN 24 HOURS)** and submitted with all other required documents to the Human Resources Department)

SECTION I: EMPLOYEE INFORMATION (Employee only)

Employee Name: _____ Date of Birth: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Last 4 of SS# _____ Sex: _____F ____M Age: _____

Job Title: _____ School/Department: _____ FT____ PT ____

Supervisor's Name: _____ Supervisor's Phone: _____

SECTION II: ACCIDENT/INCIDENT INFORMATION

Accident Date: _____ Time of Injury: _____ Location of Accident: _____
Address where injury occurred: _____ City _____ State_____ Zip _____
Time Workday Began: _____ AM_____ PM_____
Witnesses (Names/Department(s) and **phone number**):
Name: _____ Number: _____
Name: _____ Number: _____
Name: _____ Number: _____
What was the employee doing just before the accident occurred? (**Be very specific**: describe the activity, as well as the tools, equipment or material the employee was using.) _____
_____
_____

Full description of how the injury occurred. What Happened? (**Be very specific**: how did the injury occur?)
_____
_____

What was the body part injured and how was it affected (**Be specific** i.e. Left leg, Right arm)?
_____
_____
_____

What object or substance cause harm to the employee? _____
_____
_____

If the employee died, when did death occur: _____
If treatment was given on-site by school nurse or staff list name: _____
If treatment was given away from the worksite, where was it given: _____

Facility/Doctor: _____
Address: _____ City: _____ State: _____ Zip: _____
Was the employee treated in an emergency room? _____ Y _____ N
Was employee hospitalized overnight? _____ Y _____ N
Return to work date: _____

SECTION III: SUPERVISOR/DESIGNEE

This accident was reported to me on: Date: _____ Time: _____ School/Department: _____
Is further investigation required? _____ Y _____ N
Was safety equipment provided? _____ Y _____ N Was safety equipment used? _____ Y _____ N
Supervisor's Signature: _____ Date: _____

EMPLOYEE CERTIFICATION

I hereby certify that the above referenced information is true and accurate. I further understand that the information above will be used by my employer to help determine compensability for my injury and that any inaccurate or false statements offered may result in a delay in processing my claim and/or my request for Workers' Compensation Benefits.

Employee Signature: _____ Date: _____

HUMAN RESOURCES DEPARTMENT ONLY

Hire Date: _____
Title: _____
Date of Birth: _____
Social Security#: _____
State/Local/Federal Split: _____
Salary: _____
Hours worked per week: _____
Leave used: _____
Number of days with restrictions: _____