

Crowley ISD Employee Accident / Injury Report and Assessment

This form is to be completed at the time of the accident/injury and submitted to benefits specialist and director of health services the date of completion.

Page 1 of the form should be completed by the employee.

Employee's full legal name _____ Date of birth _____

Gender _____ Social Security Number _____

Phone Number _____

Home Address _____

Campus & Department of Employment _____

Supervisors Name and title _____

Date of injury _____ Time of injury _____

Time employee began work on the date of injury _____

Date injury reported _____ Time reported _____

Who was the injury initially reported to? _____

Campus and specific location, including room number, of where the accident occurred _____

Witness/person in attendance _____

Was anyone else injured? _____

Describe in detail how the accident occurred and what the employee was doing when the injury occurred.

Has the employee been absent from duty due to the accident? _____

If yes, date and time absences began _____

Please let the health services staff know if you are seeking treatment at this time.

Refer to the treatment protocol form for work related injuries.

Signature of employee _____ Date _____ Time _____

The section below must be completed by the health services staff member doing the injury assessment

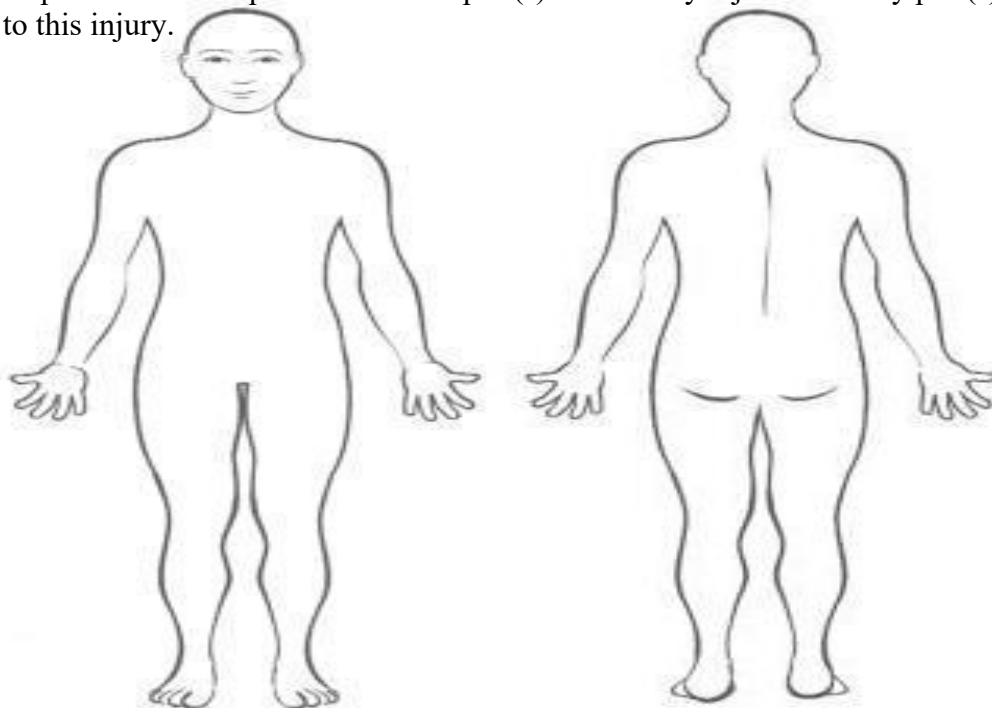
Employee's name _____ Date of injury _____

Date of assessment _____ Time of assessment _____

Describe the injury in detail, including the nature of the injury (bruise, cut, scratch) _____

What part of the body is injured (left, right, both)? _____

On the diagram provided below please circle the part(s) of the body injured and any part(s) where pain is reported due to this injury.



Treatment and disposition _____

Seeking medical care? _____ If yes, Where? _____

Was 911 called, what time? _____ Transported by ambulance? _____

FD arrival time & Staff _____ Ambulance arrival time & Staff _____

Procedure for Workers' Compensation form, including treatment information, given to staff YES NO

Printed Name & position of health services staff completing report _____

Signature of person completing report _____ Date _____ Time _____

Signature of employee after review of report _____ Date _____ Time _____