CRAWFORD COUNTY R-II SCHOOL DISTRICT
EMPLOYEE ACCIDENT REPORT

Instructions: After completion of form, keep one (1) copy for supervisor's records, two (1) copy to superintendent's office. This form is to be complete **within 48 hours after an accident.**

Employee Name_____Age_____Sex_____
Home Address_____
City, State, Zip_____
Social Security #_____Date of Birth_____Home Phone #_____
Occupation_____Hire Date_____
Date of Injury_____Time of Injury_____Location_____
How did the accident occur?_____

What was the employee doing when injured?_____

Name substance or object that directly caused injury_____

Describe, in detail, extent of injury; indicate part of body involved

Were there any witnesses?_____If yes, complete a "Report by Eyewitness" form
Were you working at your regular job at the time of injury?_____ If no, explain why_____
Did employee receive medical care?_____
Was accident site reviewed by Supervisor or Building Principal?_____
What equipment or procedure could have been used to prevent this accident?_____

Was employee wearing/using required safety equipment?_____
What immediate action has been taken to prevent the occurrence of a similar accident?_____
Any additional employee comments_____

Any additional supervisor comments_____

Was medical treatment refused?_____
Reason_____

_____ _____ _____ _____
Employee's Signature Date Supervisor's Signature Date