

Employee Accident Report – Fill Out Completely

Please forward to **Kelly Dekoski** at the administration building

Social Security No.: _____ Date of Injury: _____ Time: _____ Time you began work: _____

Name: _____ Street Address, City, State, Zip: _____

Telephone: _____ Gender: Male () Female () Age: _____ Date of Birth: _____

Job Title: _____ Name of Building: _____ Date Hired: _____

Place of Accident: School Building () School Grounds () To or from School () Home () Other _____

Nature of Injury		DESCRIPTION
Nature of Injury	Abrasion _____ Concussion _____ Puncture _____ Amputation _____ Cut _____ Scalds _____ Asphyxiation _____ Dislocation _____ Scratches _____ Bite _____ Fracture _____ Shock _____ Bruise _____ Laceration _____ Sprain _____ Burn _____ Poisoning _____ Strain _____ Illness _____ Other (specify) _____	What was the employee doing before the incident occurred? _____ _____ What happened? _____ _____ _____ What was the injury or illness? _____ _____
	(indicate left or right where applicable) Abdomen _____ Eye _____ Leg _____ Ankle _____ Face _____ Mouth _____ Arm _____ Finger _____ Nose _____ Back _____ Foot _____ Scalp _____ Chest _____ Hand _____ Tooth _____ Ear _____ Head _____ Wrist _____ Elbow _____ Knee _____ Other (specify) _____	What object or substance directly harmed the employee? _____ _____ If the employee died, when did death occur? _____ _____

Degree of Injury: No disability () Temporary Disability () Permanent Impairment () Death ()
 Did you stop work as a result of your accident? _____ When? _____ Last day worked? _____
 If not working, when do you expect to return to work? _____ If you did return, list the date? _____

Immediate Action Taken	
Immediate Action Taken	(Treatment provider is: Hurley Occupational Health Services; Hurley Urgent Care, Grand Blanc Urgent Care and Clio Urgent Care) Treatment not necessary _____ First-aid treatment received _____ by (name): _____ Sent to occupational clinic _____ by (name): _____ located at: _____ Sent to after-hours clinic _____ by (name): _____ located at: _____ Sent to emergency care _____ by (name): _____ name of facility: _____ Names of witnesses: _____

Location		
Location	Specify Activity Athletic field _____ Pool _____ Auditorium _____ Sch. Grounds _____ Cafeteria _____ Showers _____ Classroom _____ Stairs _____ Corridor _____ Supply room _____ Gymnasium _____ Toilet room _____ Locker room _____ Other (specify) _____	What recommendations do you have for preventing other accidents of this type? _____ _____ _____
	(fill out completely & obtain supervisor's signature)	

Employee Signature: _____	Supervisor Signature: _____
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