DEERFIELD COMMUNITY SCHOOL DISTRICT

EMPLOYEE ACCIDENT REPORT FORM

To be completed and signed by employee then turned into the building secretary or direct supervisor, and then routed to Human Resources.

GENERAL INFORMATION:

Employee Name _____ Phone Number _____

Address _____ City, State, Zip _____

Position _____ Work Location_____

Hire Date _____ Date of Birth _____

ACCIDENT INFORMATION:

Date of Accident _____ Time of Accident _____ Location of Accident _____

Detailed description of what happened _____

_____

_____

Specifically what were you doing _____

_____

Describe precisely the pain you felt (sharp, dull) and noise heard (snap, pop, pull, sharp, from waist to knee, etc.)

_____

_____

Specific location of pain (lower back, right knee, etc.) _____

Nature of injury (bruise, twist, cut, scratch, broken skin, etc.) _____

Did accident involve an unsafe act? Describe _____

Did accident involve an unsafe condition? Describe _____

How could accident have been prevented? _____

Medical treatment? Name of Doctor, Hospital, etc. _____

Did accident involve a District policy? Describe _____

Name(s) of Witnesses _____

EMPLOYEE MUST ALSO CALL MEDCOR – 800-775-5866 IN ADDITION TO COMPLETING FORM

Employee Signature _____ Printed Name _____

Date Reported _____ Date Received _____ Received by _____
