Shelby County Schools

Employee Accident Report Form

EMPLOYEE INFORMATION

Full Name: _____

SSN: _____ **Date of Birth:** _____ **Gender:** _____

Address: _____

City, State, Zip: _____

Date Hired: _____ **Employee Type:** _____

Job Title: _____ **Work Location:** _____

Email: _____ **Personal Phone:** _____

Is the Employee covered by Board Insurance? ☐ Yes ☐ No

Date of Incident: _____ **Time of Incident:** _____ **Time Employee Began Work:** _____

Date Reported to Supervisor: _____ **Time Reported to Supervisor:** _____

Incident Type: ☐ Accident ☐ Exposure

Give a clear description of the incident and how it occurred: _____

Check Appropriate Action Required: ☐ Ambulance Required ☐ First Aid Only ☐ No Treatment Needed ☐ Emergency Treatment ☐ Hospitalization ☐ SCS Clinic

Body Part(s) Injured: _____ **Injury Type(s):** _____

What caused the incident? _____

What object or substance directly harmed the employee? _____

OSHA Case Classification: _____ **# Days Away From Work:** _____

OSHA Injury Type: _____ **Anticipated Return Date:** _____

Actual Return Date: _____ **Physical Assault?** ☐ Yes ☐ No

Was Personal Protection Equipment Required? ☐ Yes ☐ No

Was Employee using Personal Protection Equipment? ☐ Yes ☐ No

Reporting Location: _____ **Report Prepared by:** _____

Reporting Location Comments: _____

This form should be submitted to the main office for entry into the online Employee Accident Reporting system.