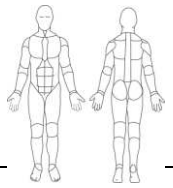
South Washington County Schools
Employee Incident Report Form

Please print clearly. This report must be submitted within 24 hours of injury/illness to Human Resources - Benefits Staff
Fax Completed form to 651-458-6258

Claim Information			
Employee's Name:			Social Security # (last 4 digits)
Home Address: (Street)	(City)	(State)	(Zip)
Home Phone:	Gender: ☐ Male ☐ Female	Date of Birth:	
Marital Status: ☐ Married ☐ Unmarried	Date of Hire:		
Occupation:	Employee Group/Department:		
Supervisor's Name:	Supervisor's Phone Number:		
Date of Injury:	Time of Injury: ☐ AM ☐ PM	Time Workday Began: ☐ AM ☐ PM	
Did the accident occur at the work location: ☐ Yes ☐ No Which building:			
If no, where did the accident occur? (Street)	(City)	(State)	(Zip)
Give a full description of how the accident occurred.			
Date and time reported to employer:	Person injury reported to:		
Injury Description:			
Date of Death (if applicable):	Is Employee Hospitalized: ☐ Yes ☐ No		
Which part of the body was injured? (Please shade in the area on the body diagram to the right) ☐ Neck ☐ Upper Back ☐ Lower Back ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand ☐ Leg ☐ Knee ☐ Ankle ☐ Foot ☐ Other _____ Part of body Location: ☐ Left ☐ Right ☐ Both			
Has the employee lost time? ☐ Yes ☐ No	If yes, when was the first full day out?		

Medical Information					
Initial Medical Treatment:					
Medical Treatment: ☐ Yes ☐ No	Refused to see Doctor: ☐ Yes ☐ No	Minor/Onsite First Aid: ☐ Yes ☐ No			
Physician/Clinic : ☐ Yes ☐ No	ER Treated and Released: ☐ Yes ☐ No	Hospitalized: ☐ Yes ☐ No			
Clinic/Doctor: ***Complete only if employee was treated at clinic***					
(Name of Clinic/Doctor)	(Address)	(Phone Number)			
Hospital: ***Complete only if employee was treated at hospital***					
(Name of Hospital)	(Address)	(Phone Number)			

Witness Information
Were there any witnesses? ☐ Yes ☐ No
If yes, list names and how to contact them:

Comments

Employee Signature: _____ **Date:** _____

Supervisor's Signature: _____ **Date:** _____