Employee Accident Report Form

White Bear Lake Area Public Schools

Please print clearly. This report must be submitted within 24 hours of injury/illness to the Human Resource Office at the District Center.
Fax Completed form to 651-407-7541

Claim Information			
Injured Employee's Name:			
Home Address: (Street)	(City)	(State)	(Zip)
Home Phone:	Gender: ☐ Male ☐ Female	Date of Birth:	
Occupation:	Department Name:		
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: ☐ 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:** ____________________

Revised June, 2009