OAK CREEK-FRANKLIN JOINT SCHOOL DISTRICT

Procedure for Policy 523 (2 - Form): Employee Injury/Accident Report

This form is to be completed within 24 hours of contacting Medcor. If the employee received emergency medical treatment, this form should be completed as soon as reasonably possible after the occurrence of the injury.

EMPLOYEE INFORMATION	
Employee Name: *(Last, First, MI)*	
Employee Address: *(Street, City, State)*	
Home/Cell Phone Number:	**Work Phone Number:**
Date Completing Form:	**Building/Site where injury occurred:**
Location within building/site where accident occurred:	**Name of Person Notified:**
Date of Accident/Injury:	**Time of Accident/Injury:**
Describe task(s) you were performing when injured and what caused the accident/injury:	**Body Part Injured:** ____ Wrist ____ Hand ____ Leg ____ Knee ____ Foot ____ Ankle ____ Head ____ Face ____ Eye ____ Teeth ____ Neck ____ Chest ____ Abdomen ____ Arm ____ Back ____ Other *(specify)*: _____
Type of Injury: ____ New ____ Re-injury ____ Prior work-related injury	
Describe any resulting injury:	
Employee Signature:	**Date:**
TREATMENT INFORMATION	
Did you receive medical attention or treatment: ____ Yes ____ No	
If yes, Time: _____ **Date:** _____	**If no, why not?**
Name of Provider:	**Address of Provider:**
Principal/Supervisor's Signature:	**Date:**

Part 2: Accident/Injury Follow-up and Investigation *(to be completed by building administrator or district safety coordinator)*

Interviewed Injured Employee: Yes or No *(circle one)*	If yes, Date:		
Interviewed Witness(es): Yes or No *(circle one)*	If yes, Date(s):		
Witness 1 Name:			
Witness 1 Phone Number:	**Witness 1 Address:**		
Witness 2 Name:			
Witness 2 Phone Number:	**Witness 2 Address:**		
Witness 3 Name:			
Witness 3 Phone Number:	**Witness 3 Address:**		
Please answer the following question by circling Yes, No or Not Applicable:			
1. Was the injured employee properly instructed in safe methods?	Yes	No	NA
2. Did the employee violate any instructions, policies, or procedures?	Yes	No	NA
3. Was necessary protective equipment worn?	Yes	No	NA
4. Did poor cleaning/maintenance contribute to the accident?	Yes	No	NA
5. Was the accident caused by something which needed repair?	Yes	No	NA
6. Was the accident caused by an unsafe act or behavior?	Yes	No	NA
What do you consider the root cause of the accident?			
What steps are being taken to prevent similar accidents?			
Lost Time from Work (if applicable):	Hours:	Days:	
Date Returned to Work:	**Accommodations Required?** Yes or No		
Additional Notes/Comments: *(optional)*			
Name of Person Completing This Report:			
Title:	**Building**		
Signature of Person Completing Report:	**Date:**		

(rev. July 2016)