Prairie Central C.U.S.D. #8
Employee Accident/Injury Investigation Report

Employee Name:____

Employee's Information:

DOB:____________ SS#:____________________ Home Phone #: __________________

Address:____

Building: ____________________________ Job Title: ____________________________

Accident Information:

Date of Accident/Injury: ________________ Time:________ Location: _______________

Witness(es):____

Description of accident/injury: ____

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Nature and extent of injury: ____

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____

How was the injury treated (first aide, EMS, hospital, etc.)?____________________________

____

Was a physician or specialist seen for the injury? Yes____ No____

Physician's Name: ____

Physician's Address: ____

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Did employee miss time from work due to injury? Yes____ No____

If so, how many days? ____

Administrator's Signature: __________________________________ Date:_______________

**** Accident report must be filled out immediately for every employee accident and submitted to the Unit Office within two (2) days of the accident. ****