MECOSTA-OSCEOLA ISD EMPLOYEE ACCIDENT/ INJURY REPORT

To be completed by the employee and submitted to the Supervisor immediately following a workplace injury.

PERSONAL INFORMATION

NAME / POSITION

HOME ADDRESS

PHONE NUMBER

GENDER ☐ Male ☐ Female

DOB

SS#:

INJURY INFORMATION

DATE OF INJURY

TIME

DATE/TIME INJURY REPORTED:

REPORTED TO:

REPORTED BY: (if other than the injured)

STUDENT INVOLVED: (name)

LOCATION (i.e. classroom, hallway,)

WITNESSED BY: (names)

DID YOU SEEK MEDICAL TREATMENT? ☐ YES ☐ NO

WHEN WHERE WHAT:

DID YOU STOP WORK AS A RESULT OF YOUR INJURY? ☐ YES ☐ NO

WHEN Explain:

WHAT PART(S) OF YOUR BODY WERE INJURED? (**Be specific**)

DESCRIBE IN DETAIL HOW THE ACCIDENT/ INJURY HAPPENED: (what you were doing, the direct cause of injury, what type of injury, immediate onset and delayed onset symptoms,etc. Continue on back if necessary.)

EMPLOYEE SIGNATURE:

DATE:

ADDITIONAL INFORMATION REGARDING INJURY (continued)

SUPERVISOR USE ONLY

DOES EMPLOYEE INJURY REQUIRE TREATMENT AT OCCUPATIONAL HEALTH?

☐ YES ☐ UNKNOWN (explain)
☐ NO

NOTES:

SUPERVISOR SIGNATURE:

DATE: