REPORT OF ON-THE-JOB-INJURY
ALEXANDER CITY BOARD OF EDUCATION

DIECTIONS: This report must be completed by the employee immediately (but no later than 24 hours after injury) following an on-the-job injury and filed with the Central Office.

PLEASE NOTE: The report must be signed by both the employee and the employee's immediate supervisor.

Name of Injured: _____

Address: _____ **Phone:** _____

Date of Injury: _____ **Time of Day Injury Occurred:** _____

Where Did Injury Occur: _____

Nature of Injury: _____

Describe How Injury Occurred: _____

_____

Was Immediate Supervisor Notified? Yes ___ No ___

Date and Time Immediate Supervisor Notified: _____

Name of Person Who Administered First Aid: _____

Were You Seen by a Physician? Yes ___ No ___ Physician's Name: _____

Were You Taken to a Hospital? Yes ___ No ___ Hospital Name: _____

Name(s) of Witness(es) _____

Your signature below verifies that the above-described injury occurred while working in the line of duty as an employee of the Board.

_____ _____

Employee Signature **Date**

THIS SECTION TO BE COMPLETED BY THE IMMEDIATE SUPERVISOR

Nature of Injury _____

In Your Opinion, How did the Injury Occur? _____

_____

_____ _____

Signature of Immediate Supervisor **Date**

Date Report Submitted: _____