SEASIDE SCHOOL DISTRICT 10

Employee Accident Report

This form is to be completed by the employee if the employee has been injured. If medical attention is sought after this report is filled out, use this information to fill out the required 801 Form.

_____ _____

Employee's Name Job Title

_____ _____

Employee's Hours at Time of Accident (i.e. 8am-2pm) Hours Worked per Day (i.e. 5-1/2)

_____ _____

Time of Accident Date of Accident

Describe what happened and if any treatment was used:

Where did the accident take place (*building & location in building*)?

List part(s) of the body injured (*be very specific*):

What can be done to prevent this from happening again?

Name(s) of any witnesses:

Any additional comments:

_____ _____

Employee Signature * Date

_____ _____

Supervisor Signature * Date

* By typing your name here, you are signing this form electronically. You agree your electronic signature is the legal equivalent of your manual signature on this form.

Original is filed in building office; send copy to District Office.

If medical treatment for this accident is received at a later date, then you MUST fill out an 801 Form (located in the office).