VERNONIA
SCHOOL DISTRICT 47J

EMPLOYEE ACCIDENT REPORT FORM

Employee Name: _____

Date of accident/injury: _____ Time: _____

Witnessed By _____

Location accident/injury occurred: _____

How did it the accident/injury happen? _____

_____

_____

What was your injury? _____

_____

_____

Action taken: _____

_____

_____

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Superintendent Signature: _____ Date: _____

Business Office Review: _____ Date: _____

10/2015