

THIS FORM MUST BE FILLED OUT COMPLETELY
Swartz Creek Community Schools
STAFF ACCIDENT REPORT OF INJURY
(Please Print)

Injury date:	Claim Number:
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EMPLOYEE INFORMATION

Employee's last name:		First:	Middle Initial:	Marital status: (circle one)	
				Single / Mar / Sep	
Social Security number:	Home phone number:	Birth date:	Sex:	Time you began work on day of injury:	
	()	/ /	<input type="checkbox"/> M <input type="checkbox"/> F		
Employee's street address:		City:	ZIP Code:		
Occupation:	Building Assignment:	Hire Date:	Rate of Pay:		

ACCIDENT INFORMATION

Date of injury:	Time of injury:	Injury reported to:	Date reported to supervisor:
	am/pm		
Witness(es) to injury:			
Describe in <u>DETAIL</u> how injury happened:			
What part(s) of your body was/were injured: (please specify right or left if needed)			Nature of injury: (i.e. cut, sprain, bruise)
Was there time missed from work?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dates/ times of missed work:	
Doctor Consulted?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

IF A DOCTOR WAS NOT CONSULTED THEN PLEASE STOP HERE

TREATMENT INFORMATION

Name of treatment facility:			
Date of initial treatment:			
Did the physician put you off work?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, until what date?	
Did the physician restrict your work?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what are your restrictions?	
Do you have a follow-up appointment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when?	

BOTH SIGNAUTRES REQUIRED

Employee Signature	Date	Supervisor Signature	Date
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Pease return this form to Angie Zedo in the Business Office within 24 hours after treatment has been rendered. If no treatment was sought, please return within 24 hours of injury.