Employee Accident Report Form

White Bear Lake Area Public Schools

Please print clearly. This report must be submitted within 24 hours of injury/illness to the Human Resource Office at the District Center.
Fax Completed form to 651-407-7541

Claim Information

Injured Employee's Name:

Home Address: (Street)	(City)	(State)	(Zip)
Home Phone:	Gender: ☐ Male ☐ Female	Date of Birth:	

Occupation:	Department Name:
Supervisor's Name	Supervisor's Phone Number:

Date of Injury:	Time of Injury: ☐ AM ☐ PM	Time Workday Began: ☐ AM ☐ PM

Did the accident occur at the work location: ☐ Yes ☐ No Which building:

If no, where did the accident occur? (Street)	(City)	(State)	(Zip)

Give a full description of how the accident occurred.

Date and time reported to employer:	Person injury reported to:

Injury Description:

Date of Death (if applicable):	Is Employee Hospitalized: ☐ Yes ☐ No

Which part of the body was injured:
☐ Neck ☐ Upper Back ☐ Lower Back ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand ☐ Leg ☐ Knee ☐ Ankle ☐ Foot
☐ Other ______________________________

Part of body Location:
☐ Left ☐ Right ☐ Both

Has the employee lost time? ☐ Yes ☐ No	If yes, when was the first full day out?

Medical Information

Initial Medical Treatment:

Medical Treatment:	☐ Yes ☐ No	Refused to see Doctor:	☐ Yes ☐ No	Minor/Onsite First Aid:	☐ Yes ☐ No
Physician/Clinic :	☐ Yes ☐ No	ER Treated and Released:	☐ Yes ☐ No	Hospitalized:	☐ Yes ☐ No

Clinic/Doctor: ***Complete only if employee was treated at clinic***

(Name of Clinic/Doctor) (Address) (Phone Number)

Hospital: ***Complete only if employee was treated at hospital***

(Name of Hospital) (Address) (Phone Number)

Witness Information

Were there any witnesses? ☐ Yes ☐ No

If yes, list names and how to contact them:

Comments

Employee Signature: ______________________________ **Date:** ____________________

Supervisor's Signature: ______________________________ **Date:** ____________________

Revised June, 2009