Kenyon-Wanamingo Public Schools ISD #2172	**Report of Accident/Injury Form** **COMPETE REPORT IMMEDIATELY AND SPEAK TO SUPERVISOR ON DATE OF INCIDENT**

Name of Employee: _____ Supervisor Reported to: _____

Date and Time of Incident/Accident: _____ _____ AM____ PM____
Month/Day/Year Time

Time Employee began work on date of accident: _____ AM or PM

Did Employee Lose Time from Work? ____Yes ____ No Hours Lost on Date of Accident _____

Has Employee Returned to Work? ____Yes ____No Job Title: _____

Accident: (*Describe what injured was doing at time of accident, what happened, who was involved)*_____

_____

_____

Injury: *(Describe nature of injury, part of body affected, left or right side, etc.)* _____

_____

What tools/equipment/objects/machines or substances involved were involved? _____

_____

Location: *(Describe where the accident occurred*; *i.e., entry, classroom, hallway, gymnasium, cafeteria, inside/outside building).* _____

_____

Was there a witness to the incident: ____Yes ____ No

Witness Name and Phone: _____ (____) ____ - _____

Was medical attention necessary? ____ Yes ____No

Did employee go to doctor or hospital? ____ Yes ____No Date of initial visit: _____
Month/Day/Year

Treating Physician (Name/Address/Phone)
Name _____
Address _____
City ST Zip _____

Hospital/Clinic (Name/Address/Phone)
Name _____
Address _____
City ST Zip _____

Signature of Injured Party: _____ Date: _____

Employee to complete and return form to Supervisor same day of accident/injury.