SUMTER COUNTY BOARD OF EDUCATION
Accident/Injury Report

Please fully complete this report. Be aware that all reports of work-related injury or illness will be investigated, and that any fraudulent reports/claims will be prosecuted to the fullest extent of the law.

TODAY'S DATE_____ EMPLOYEE NAME_____

SS#_____ DATE OF BIRTH____/____/_____ AGE_____ SEX_____

TELEPHONE#_____ ADDRESS (give street address)_____

_____

NAME & TELEPHONE OF NEAREST FRIEND/ RELATIVE_____

WHO IS YOUR PERSONAL/FAMILY PHYSICIAN?_____

SCHOOL OR LOCATION WHERE ACCIDENT OCCURRED_____

DATE OF INJURY_____/_____/_____ HOUR OF DAY_____ DAY OF WEEK_____

IF THE DATE OF INJURY IS DIFFERENT FROM TODAY'S, EXPLAIN WHY INCIDENT IS BEING REPORTED LATE_____

_____

DID YOU TELL YOUR SUPERVISOR?_____ SUPERVISOR'S NAME? _____

WERE THERE ANY WITNESSES? _____ IF YES, PLEASE LIST THEM _____

_____

DID YOU CONTINUE TO WORK?_____

DESCRIBE FULLY HOW ACCIDENT OCCURRED, NAMING THE MACHINE, TOOL OR THING CAUSING THE INJURY, AND STATE WHAT YOU WERE DOING WHEN INJURED: _____

_____

_____

_____

LOCATION ON BODY OF INJURY. (DESCRIBE FULLY THE EXACT LOCATION OF INJURY, RIGHT OR LEFT, ETC.)_____

_____

WERE GUARDS AND/OR SPECIAL SAFETY EQUIPMENT REQUIRED FOR JOB YOU WERE PERFORMING?_____ WERE THEY IN PLACE AT TIME OF ACCIDENT?_____IF NO, PLEASE EXPLAIN

_____

IF YES, PROVIDE DETAILS_____

_____

HAVE YOU EVER HAD A SIMILAR PAIN OR INJURY BEFORE?_____ IF YES, PLESE LIST DETAILS

_____

WAS IT DUE TO AN ON-THE-JOB INJURY?_____

PLEASE TELL US IF YOU THINK THERE IS ANYTHING THAT COULD BE DONE TO PREVENT THIS ACCIDENT/INJURY FROM HAPPENING AGAIN_____

_____

DO YOU FEEL YOU RECEIVED APPROPRIATE SAFETY TRAININNG FOR THE JOB YOU WERE ON WHEN THIS INJURY OCCURRED?_____

My signature below indicates that I have completed this accident/injury report in my own handwriting, or if unable to do so, the responses filled out by my employer have been reviewed with me, and that everything contained in this report is accurate and true.

EMPLOYEE SIGNATURE_____DATE_____

EMPLOYER SIGNATURE_____DATE_____

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SCHOOL/DEPARTMENT OFFICE USE ONLY

WAS FIRST AIDE APPLIED AT SCHOOL OR LOCATION? YES ( ) NO ( )

DID EMPLOYEE SEEK MEDICAL ATTENTION? YES ( ) NO ( )

IF YES, NAME OF PHYSICIAN OR HOSPITAL_____

HAS INJURED RETURNED TO WORK? YES ( ) NO ( ) IF YES, DATE_____HOUR_____

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CENTRAL OFFICE USE ONLY

SALARY_____ ACCIDENT CAUSE_____

HIRE DATE_____ INJURY TYPE_____

CLAIM STATUS_____ BODY LOCATION_____

REVISED 09/10/2015