



Complete this form for every accident or incident involving School District employees. Answer all questions completely. Fax a copy to Human Resources, 715-394-8708, as soon as possible. Send the original document to Human Resources.

<b>Employee Name</b>		<b>Position</b>	
<b>Address</b>		<b>School</b>	
<b>City, State, Zip Code</b>		<b>Accident Details</b>	
<b>Home Phone</b>		<b>Date of Accident</b>	<b>Time:</b>
<b>Birth Date</b>		<b>Accident Location</b>	<input type="checkbox"/> School Building <input type="checkbox"/> School Grounds <input type="checkbox"/> Other (Detail in box below)
<b>Sex</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female		

**Please describe in detail what happened, and which part of the body suffered injury:**

**What was the employee doing when injured?**

**Please specify any tool, machinery, equipment or safety equipment involved or in use:**

**Was employee doing his/her regularly assigned duties?**  Yes  No  
**If no, what job duties was he/she performing?**

**Was First Aid administered?**  Yes  No  
**If yes, describe treatment.**

<b>Was a doctor consulted?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Was Employee hospitalized?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Total Lost Work Days</b>	
<b>Doctor's Name &amp; Address</b>		<b>If yes, length of stay</b>		<b>Last day worked</b>	
		<b>Hospital Name &amp; Address</b>		<b>Date returned</b>	

**Send doctor's excuse to Human Resources for any lost time.  
Accidents must be excused by physician or sick leave is charged to employee.**

**Accident Witnesses:**

<b>Name</b>		<b>Position</b>	
<b>Name</b>		<b>Position</b>	

**Signatures:**

<b>Employee</b>		<b>Date</b>	<b>Building Administrator</b>		<b>Date</b>
<b>Director of Health</b>		<b>Date</b>	<b>Director of Human Resources</b>		<b>Date</b>

