EMPLOYEE ACCIDENT REPORT

CABOT SCHOOL

__M __F _____DOB _____SSN ___EMPLOYEE ___VISITOR

Name of Injured:_____

Address:_____

Home Phone:_____ Hire Date:_____ Supervisor:_____

Date of Accident:_____Time of Accident:_____On School Grounds: __Yes __No

Location of Accident:_____

Describe the Accident:_____

_____

_____

_____

_____

Names of Witnesses (Include phone Number):_____

_____

Nature of Injury:_____

_____

_____

Type of Aid Administered:_____

_____

_____

_____

Aid Administered by:_____Time:_____

Was Medical Attention Sought at Concentra: ____Yes ____No /

Name of Physician:_____

Address & Phone:_____

Time Lost from Work ____Yes ____No Date Lost Time Began:_____

Employee Hours of Work: Start Time:_____ End Time:_____ 124

Original: School Nurse / Copy: Principal / Copy: Superintendent

Cause of Accident:_____
_____
_____
_____

Describe any Unsafe Conditions:_____
_____
_____
_____

Describe any Contributing Causes:_____
_____
_____
_____

Corrective Action to be Taken:_____
_____
_____
_____

Signature of Person Completing this Report:

_____ Title:_____Date:_____Time:_____

Signature of Administrator:

_____ Title:_____Date:_____Time:_____

Original: School Nurse / Copy: Principal / Copy: Superintendent