Hutchinson Public Schools
Employee/Supervisor Accident Form

Employee Name: ______________________ Job Title: ______________________

Employee Address: ______________________

Date of Birth: ______________________ Social Security Number: ______________________

Employee Phone Number: ______________________ Date of Injury: ______________________

Supervisor Name: ______________________ Time: ______________________ Am / Pm

Location of Accident: ______________________

Specific activity when accident occurred: ______________________

____

Witnesses (names and phone numbers): ______________________

____

Circle the appropriate areas in each column:

Injured Area	Indicate Area of Injury	Type and Cause of Injury
1 Head 2 Eye L / R 3 Shoulder L / R 4 Arm L / R 5 Elbow L / R 6 Wrist L / R 7 Hand L / R 8 Finger 9 Back 10 Chest 11 Abdomen 12 Pelvis 13 Hip L / R 14 Leg L / R 15 Knee L / R 16 Ankle L / R 17 Foot L / R 18 Toe 19 Other: ________ ________________	Arm, Neck, Shoulder, Upper Back, Wrist, Hand, Elbow, Lower Back, Hip/Thigh, Lower Leg, Foot **LEFT SIDE** **RIGHT SIDE**	<u>Type:</u> • Bruise • Burn • Cut / Laceration • Fracture (possible) • Puncture • Rash • Respiratory Issue • Strain/Sprain • Other: ________ ________________ <u>Cause:</u> • Allergic Reaction • Bite • Hit/kick/scratch (student) • Lifting/Lowering • Reaching/Bending • Repetitive Motion • Slip/Trip/Fall • Struck By Object • Tool or Machine • Other: ________ ________________

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Description of what happened:

Suggestions to prevent similar injuries:

Was employee taken to the hospital/clinic: Yes No If so, by whom?____________________________

Will this injury result in at least a full day of missed work? Yes No

Injured Employee Signature:____

Supervisor Signature: ____Date: __________________

HR USE ONLY

Claim number: ____

Other Workers Compensation claims:

Signature:____ Date received in office:______________________