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: _____

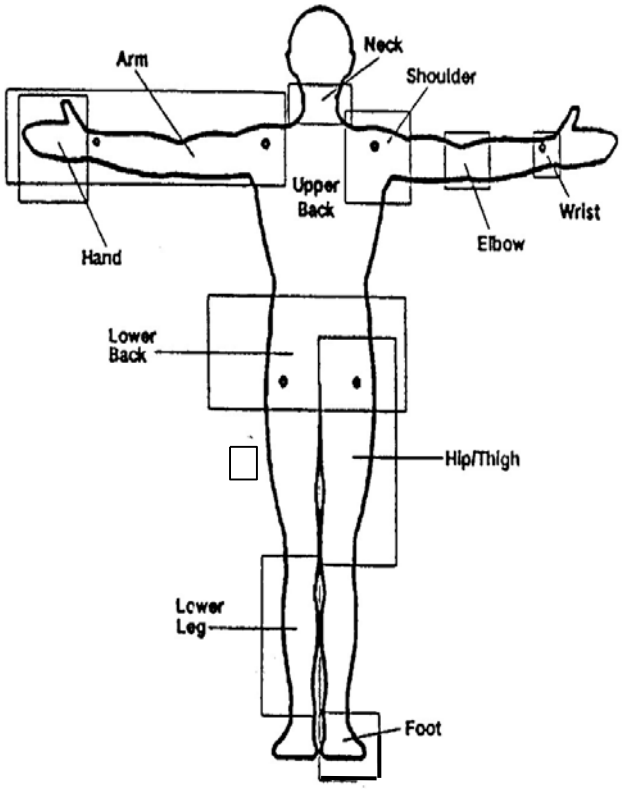
Specific activity when accident occurred: _____

_____

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: _____ _____	 **LEFT SIDE** **RIGHT SIDE**	Type: • Bruise • Burn • Cut / Laceration • Fracture (possible) • Puncture • Rash • Respiratory Issue • Strain/Sprain • Other: _____ _____ Cause: • Allergic Reaction • Bite • Hit/kick/scratch (student) • Lifting/Lowering • Reaching/Bending • Repetitive Motion • Slip/Trip/Fall • Struck By Object • Tool or Machine • Other: _____ _____

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: _____