Pleasanton Independent School District
Report of Incident

GENERAL INFORMATION

Name:		Campus/Department:	Job Classification:
Mailing Address:		City:	Zip Code:
Sex: M F	Cell Phone:	Home Phone:	**OFFICE USE ONLY:** DOH: _____ DR:_____ Hrs Wk Per Day: _____ Date of Birth: _____ SS#: _____
Number of Dependents:	Marital Status: ☐Married ☐Single ☐Widowed ☐Divorced ☐Separated		

Was employee performing his/her regular job when incident occurred? ☐ Yes ☐No
Had employee been informed of any potential hazards of his/her job? ☐ Yes ☐No

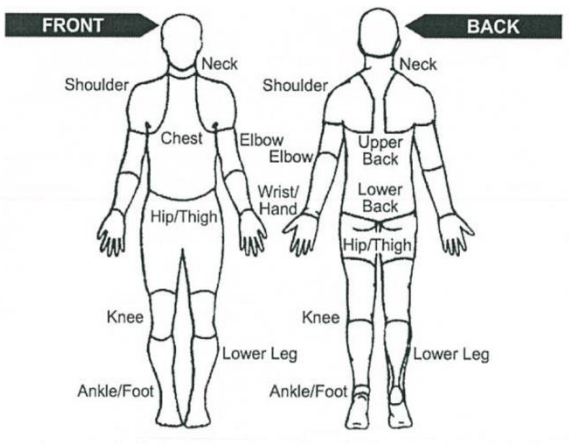
ACCIDENT INFORMATION (Must be completed by injured employee)

Date of Accident:	Location: (i.e. hallway, cafeteria, etc.)	Time of Injury: : ☐ am ☐pm

In your own words, describe in detail how the incident occurred:

Witness Names:

Shade in all the areas of discomfort



Using the scale below, rate the discomfort for both the left and the right side of the body below.

No Discomfort **Extreme Discomfort**

1 2 3 4 5 6 7 8 9 10

Discomfort Area	Right	Left
Neck		
Shoulder		
Chest		
Elbow/Forearm		
Hand/Wrist		
Hip/Thigh		
Knee		
Lower Leg		
Ankle/Foot		
Other		

Have you ever injured these body parts before? (Please indicate date, body part, and treating physician below.)

Date:	Body Part:	Treating Physician:
Date:	Body Part:	Treating Physician:

MEDICAL STATEMENT

I am declining medical attention at this time. I understand that if medical attention becomes necessary, I shall contact the Personnel Department at (830) 569-1233.
Employee Initials: _____

REQUIRED SIGNATURES

I hereby certify that the information above is true and correct to the best of my knowledge.

Employee Signature: Date:

Supervisor/Principal Signature: Date:

SEND ORIGINAL FORM TO THE HUMAN RESOURCES DEPARTMENT AS SOON AS POSSIBLE