THIS FORM MUST BE FILLED OUT COMPLETELY

Swartz Creek Community Schools

STAFF ACCIDENT REPORT OF INJURY

(Please Print)

Injury date:				Claim Number:		
EMPLOYEE INFORMATION						
Employee's last name:	First:		Middle Initial:	Marital status: (circle one)		
				Single / Mar / Sep		
Injury Date:	Home phone number:		Birth date:	Sex:		Time you began work on day of injury:
	( )		/ /	❑ M	❑ F	am/pm
Employee's street address:			City:			ZIP Code:
Occupation:	Building Assignment:		Hire Date:			Rate of Pay:

ACCIDENT INFORMATION			
Witness(es) to injury:	Time of injury:	Injury reported to:	Date reported to supervisor:
	am/pm		

Describe in **DETAIL** how injury happened:

What part(s) of your body was/were injured: (**please specify right or left if needed)**	Nature of injury: (i.e. cut, sprain, bruise)

Was there time missed from work?	❑ Yes	❑ No	Dates/ times of missed work:
Doctor Consulted?	❑ Yes	❑ No	

IF A DOCTOR WAS NOT CONSULTED THEN PLEASE STOP HERE

TREATMENT INFORMATION

Date of initial treatment:

Did the physician put you off work?	❑ Yes	❑ No	If yes, until what date?	
Did the physician restrict your work?	❑ Yes	❑ No	If yes, what are your restrictions?	
Do you have a follow-up appointment?	❑ Yes	❑ No	If yes, when?	

BOTH SIGNAUTRES REQUIRED

Employee Signature	Date	Supervisor Signature	Date

You MUST have an authorization to seek medical treatment.
Pease return this form to Corrie Wendt in the Business Office within 24 hours after treatment has been rendered. If no treatment was sought, please return within 24 hours of injury.