WEBUTUCK CENTRAL SCHOOL DISTRICT
EMPLOYEE WORK RELATED ACCIDENT REPORT
To be filed immediately after accident/injury

Name of Employee _____

Home Address _____

Phone ( ) _____

Social Security # _____ Date of Birth _____

Building or site where accident occurred _____

Specific location at building or site _____

Date of Accident_____ Time_____

Nature of injury and part(s) of body affected_____

_____

What did employee say he or she was doing when accident occurred? _____

_____

_____

How did the employee say the accident occurred? _____

_____

_____

Object/Substance that directly caused the injury to occur. _____

_____

Report prepared by_____ Date_____

Signature of School Official_____

Title_____ Date_____

Did you go to the Doctor or Hospital? _____ Yes _____ No

If Yes, Name & Address of Provider: _____

Did you lose any time besides the day of the accident: _____Yes _____ No

(Revised 3/25/04)