INDEPENDENT SCHOOL DISTRICT 16

ACCIDENT REPORT

Every accident must be reported **IMMEDIATELY**. This information is necessary to accurately process injury claims. Please complete and forward this form to the *Human Resources Department.*

Name:____________________ Soc.Sec.#:__________ Marital :_____

Address:____________________ Birth Date:__________ Gender:_____

City/State:________________ Zip Code: ______ Phone #:__________

Position:________________ Date Hired:____________ FT/PT________

Date of accident:_______ Starting Time: _____ AM/PM Time of accident:_____ AM/PM

Building / Accident location address:____________________

Describe accident: ____________________

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Part of body injured:____________________

I reported the accident to:____________________

My supervisor is:____________________

Witness to accident:____________________

All District 16 Employees seeking medical attention are expected to set up an appointment at the **Fridley Medical Center** for a medical evaluation. **(763) 785- 4500**

I lost ____ hours of time from my normal work schedule because of this injury.

________ I have an appointment at **Fridley Medical Center** on ________________

________ I will not see a physician at this time.

Name/Physician:________________ Clinic/Hospital:________________

Signed: ______________________________

Injured Employee Date

Signed:______________________________

Person completing Form for injured employee Date

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