Sausalito Marin City School District

Employee Accident Report

Name of Injured ______________________ Phone ______________________

Address ______________________ Date of Injury or Illness ______________________

City ____________ State ______ Zip Code ________ Time of Day ______________________

Was Employee unable to work on any day after injury? ☐ YES If yes, date last worked ______________ ☐ NO

Has employee returned to work? ☐ YES If yes, date returned ______________ ☐ NO

LOCATION *CHECK APPROPRIATE BOXES*

☐ Athletic Field ☐ MPR ☐ Classroom ☐ Corridor ☐ Lavatory ☐ Sidewalk ☐ Locker

☐ Science Lab ☐ Stairs ☐ Roadway ☐ Other(specify) ______________________

DESCRIPTION OF INJURY *CHECK APPROPRIATE BOXES*

☐ Abrasion ☐ Bite ☐ Bruise ☐ Cut ☐ Dislocation ☐ Fracture ☐ Internal

☐ Puncture ☐ Sprain ☐ Swelling ☐ Tooth Chipped ☐ Tooth Loosened ☐ Tooth Lost

☐ Other(specify) ______________________

PART OF BODY INJURED *CHECK APPROPRIATE BOXES*

☐ Ankle ☐ Arm ☐ Back ☐ Chest ☐ Chin ☐ Ear ☐ Eye

☐ Finger ☐ Foot ☐ Hand ☐ Head ☐ Hip ☐ Knee ☐ Leg

☐ Lip ☐ Mouth ☐ Neck ☐ Shoulder ☐ Tooth ☐ Wrist

☐ Other(specify) ______________________

DESCRIPTION OF THE ACCIDENT

How did the accident happen? What was employee doing? Where was employee? Specify machinery or equipment involved?

____

What action was taken to prevent accident from recurring?

____

Was there a violation of approved safety practices/standards? If yes what? Was a safety device provided? If yes, was it in use at the time?

____

Names of witnesses: ______________________

Administrator in charge when accident occurred (enter name) ______________________

Present at scene of accident ☐ YES ☐ NO

IMMEDATE ACTION TAKEN *CHECK APPROPRIATE BOXES*

☐ Sent to School nurse ☐ First Aid ☐ Sent Home ☐ Sent to Hospital ☐ Sent to Physcian ☐ Contact PDI ☐ Received DWC-1

Name of Hospital and/or Physician ______________________

______________________ ______________________

Administrator Signature Date Employee Signature Date

Revised 10/12