Doddridge County Schools

Employee Accident Report

Instructions: All questions must be answered. Complete this form when accident occurs and send over to Payroll Coordinator immediately.

Date of Injury ________________ Employee's Name ________________________________

SSN ________________________ Address ____

Phone No.:___________________ Date of Birth ______________ Gender ☐ Male ☐ Female

Marital Status ☐ Married ☐ Divorced ☐ Single Job Title ____________________________

Primary Work Location ____________________ Accident Location ____________________

Safety Equipment Provided ☐ Yes ☐ No Safety Equipment Used ☐ Yes ☐ No

If Yes, what type____

Injured body part(s) ____

Nature of the Injury (Sprain, Strain, etc.)____

Type of injury (fall, slip or trip, etc.)____

Describe Accident ____

____

____

____

What time begin work on date of injury _________ What time accident occur______________

Who was notified of accident______________________ Date notified ___________________

Did employee stop work? ☐ Yes ☐ No If yes, last day worked: _______________________

Time stopped work _____________ Date return to work _________________________

Medical Treatment ____

Medical Provider, if applicable ____

Method of Transportation to Medical Provider ____

Comments ____

Adult and/or student witnesses to accident:

Witness Name _________________________________ Contact Number _________________

Witness Name _________________________________ Contact Number _________________

Signature of Employee _________________________________ Date____________________

Signature of Supervisor ________________________________ Date____________________