SCHOOL DISTRICT OF WAUPACA
EMPLOYEE ACCIDENT REPORT

The report below must be filled out completely and returned to the Business Office immediately following any work related injury or illness.

Injured Employee _____ Job Title _____

Injury Date _____ Time _____ AM – PM

Exact Location of where accident took place (inside, outside, building name, room, vehicle, etc.: _____

_____

_____

Date Reported _____ Last Day Worked _____

Did Employee Return to Work? Yes No If Yes, Date Returned _____

Did Employee Receive Medical Attention (Doctor/Hospital) Yes No

If Yes, Name & Address of Doctor/Hospital _____

_____

_____

Describe in detail what you were doing when the injury / illness occurred. How exactly did it happen?

_____

_____

_____

What happened to cause this injury or illness? (Describe how the injury occurred) _____

_____

_____

What was the injury or illness? (State the part of body affected and how it was affected) _____

_____

Part of body injured (Check *ALL* that apply, and circle appropriate position) (Thumb = Finger 1, Great toe = Toe 1)																					
	Abdomen		Back U M L		Finger R L 1 2 3 4 5		Head		Mouth		Shoulder R L										
	Ankle R L		Eye R L		Foot R L		Knee R L		Neck		Toe R L 1 2 3 4 5										
	Arm R L		Elbow R L		Hand R L		Leg R L		Nose		Wrist R L										
	Other (Please specify)																				

Witnesses_____

Did equipment malfunction? Yes No

What action has been or will be taken to prevent recurrence? _____

_____

Please read carefully. I certify that the above statements are true and accurate and I understand that a false worker's compensation claim is a violation of Wisconsin criminal code, which may result in a fine, imprisonment, or termination from employment.

Employee Signature _____ Date _____

Principal/Supervisor Signature _____ Date _____