Employee Initial Injury Report
West Branch Local Schools

Employee's Name_____ **I.D./S.S. No.** _____

Home Address _____ **Building** _____

_____ **Home Phone**_____

County of Residence_____ **Birthdate**_____

Marital Status ____**Married** ____**Single** ____**Divorced**

INFORMATION TO BE COMPLETED BY THE EMPLOYEE

Time of Accident_____**a.m.**___ **p.m.**___ **Date** _____

Activity_____ **Place**_____

Witnesses to Accident_____

Date Reported and to Whom _____

Where Injury Occurred (i.e., classroom, gym, stairs, etc.) _____

Describe What Caused Injury _____

_____

_____

_____

_____

Employee's Signature _____ **Date**_____

POST ACCIDENT INFORMATION

Was First Aid Required	**Yes**___	**No**___
Sent or Taken Home	**Yes**___	**No**___
Sent to Hospital Emergency	**Yes**___	**No**___

Name of Person Giving Initial Treatment _____

Comments Including What Has Been Done to Prevent a Reoccurrence _____

_____

_____

Signed (Immediate Supervisor) _____ **Date** _____

(THIS FORM MUST BE RETURNED TO TREASURER'S OFFICE IMMEDIATELY)