Report of Accident/Incident Form
Kenyon-Wanamingo Public Schools #2172

Name of Employee: _____ Reported to: _____

Date and Time of Incident/Accident: _____ _____ AM____ PM____
Month/Day/Year Time

Did Employee Lose Time from Work? ____Yes ____ No Hours Lost on Date of Accident _____

Has Employee Returned to Work? ____Yes ____No Job Title: _____

Accident: (*Describe what injured was doing at time of accident, what happened, who was involved, nature of injury, part of body affected, left or right side, tools/equipment/objects or substances involved*). _____

_____

_____

Location: *(Describe where the accident occurred*; *i.e., entry, classroom, hallway, gymnasium, cafeteria, inside/outside building).* _____

_____

Was there a witness to the incident: ____Yes ____ No

Witness Name and Phone: _____ (____) ____ - _____

Was medical attention necessary? ____ Yes ____No

Did employee go to doctor or hospital? ____ Yes ____No Date of initial visit: _____
Month/Day/Year

Treating Physician (Name/Address/Phone)

Name _____

Address _____

City ST Zip _____

Hospital/Clinic (Name/Address/Phone)

Name _____

Address _____

City ST Zip _____

Signature of Injured Party: _____ _____
Date

Employee to complete and return form to Supervisor within 24 hours of the accident/incident.

Revised October 23, 2015