

PART A – EMPLOYEE INFORMATION

Name _____ Home Phone No. _____

Address _____ Postal Code _____

Home School _____ Position _____ Employee No. _____

Date of Birth: Day _____ Month _____ Year _____ S.I.N. _____

ACCIDENT DATA:

Location Where Accident Occurred _____

Date and Time of Accident: Day _____ Month _____ Year _____ at _____ a.m. p.m.

To Whom Reported _____ Position _____

Date and Time Reported: Day _____ Month _____ Year _____ at _____ a.m. p.m.

Describe what happened to cause the injury, stating all injuries and indicating right or left: _____

Witness(es) to accident:

1. _____ 2. _____

Name of hospital, if any, where treatment was received: _____

Full name and address of attending doctor: _____

Was first aid given? If so, by whom? _____

Employee's Signature _____ Date _____

PART B – IMMEDIATE SUPERVISOR INFORMATION

Time Lost? Yes No

If yes, please complete the following:

Date and hour last worked following the accident: Day _____ Month _____ Year _____

Time _____ a.m. p.m.

Has the worker returned to work? Yes No

When? – Date: Day _____ Month _____ Year _____ Time _____ a.m. p.m.

Signature of Immediate Supervisor _____ Position _____ Date _____

PART C – PRINCIPAL/ADMINISTRATOR/MANAGER

Signature of Principal/Administrator/Manager _____ Position _____ Date _____