

**SAN ANGELO INDEPENDENT SCHOOL DISTRICT  
EMPLOYEE ACCIDENT AND INJURY REPORT**  
*Print or Type*

Employee Name \_\_\_\_\_ Sex Male  Female  Birthday \_\_\_\_\_  
Last First MI Month Day Year

Mailing Address \_\_\_\_\_ Home Telephone # \_\_\_\_\_  
Street City Zip Code

Social Security # \_\_\_\_\_ Date of Hire \_\_\_\_\_ Occupation of Injured Worker \_\_\_\_\_  
Month Day Year

Marital Status Married  Divorced  Time Employee \_\_\_\_\_ am  Time of \_\_\_\_\_ am   
 Single  Separated  Number of Dependents \_\_\_\_\_ Began Work \_\_\_\_\_ pm  Injury \_\_\_\_\_ pm

Date of Injury \_\_\_\_\_ Lost Time Began \_\_\_\_\_ Was it a full day? Yes  No   
Month Day Year Month Day Year

If Time Lost: Date of *Return* to Work \_\_\_\_\_ - Or - *Expected* Date of Return to Work \_\_\_\_\_  
Month Day Year Month Day Year

Supervisor's Name \_\_\_\_\_ Supervisor's Phone # \_\_\_\_\_

Date Reported \_\_\_\_\_ Time Reported \_\_\_\_\_ am   
Month Day Year pm

Type of Injury/Illness \_\_\_\_\_ Object, tool, or cause of injury \_\_\_\_\_  
(strain, sprain, cut, burn, foreign object in eye, bite, etc.) (slip, trip, fall, vehicle, falling object, etc.)

*Specific* Body Part Affected \_\_\_\_\_ Equipment, chemicals, or materials being used \_\_\_\_\_  
(right, left, upper, lower, back, leg, knee, arm, shoulder, hand, finger, head, etc.)

Location of Injury \_\_\_\_\_  
(campus, department, or other site) (stairs, classroom, cafeteria, kitchen, dock, hallway, parking lot, etc.)

Describe fully how accident occurred \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Were safeguards or safety equipment provided? Yes  No  Were these safeguards or safety equipment used? Yes  No

Treating Doctor (*only if medical attention was required*) \_\_\_\_\_

Doctor's Address \_\_\_\_\_

Witness(es) \_\_\_\_\_  
 \_\_\_\_\_

***For Personnel Department Use Only***

Last Paycheck: Date \_\_\_\_\_ Amount \_\_\_\_\_ Bi-Weekly  Monthly

Rate of Pay: Hourly \_\_\_\_\_ Weekly \_\_\_\_\_

- |                     |                          |                            |                          |
|---------------------|--------------------------|----------------------------|--------------------------|
| Report Only         | <input type="checkbox"/> | Employee's Signature Sheet | <input type="checkbox"/> |
| Lost Time Claim     | <input type="checkbox"/> | TWCC-6                     | <input type="checkbox"/> |
| Employee Rights     | <input type="checkbox"/> | Leave Offset               | <input type="checkbox"/> |
| Record Injury       | <input type="checkbox"/> | FMLA Notice                | <input type="checkbox"/> |
| Claims Log          | <input type="checkbox"/> | Wage Statement             | <input type="checkbox"/> |
| Supervisor's Report | <input type="checkbox"/> |                            |                          |

**SUPERVISOR'S INVESTIGATION OF ACCIDENT**  
*Print or Type*

Was the employee performing his/her regular job at the time of the injury?       yes     no

Had the employee been instructed regarding hazards of the job?                 yes     no

**UNSAFE CONDITIONS/ACTS:**

What was unsafe concerning the machine, tool, equipment, premises, or vehicle? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Why did the unsafe condition exist? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What did anyone do or fail to do that led to this accident? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ACTION(S) FOR PREVENTING SIMILAR ACCIDENT:**

What action has been or should be taken to prevent a similar accident? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Printed Name of Supervisor

\_\_\_\_\_  
Signature of Supervisor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Employee

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date