Revised
07/14/2008

POINT ISABEL INDEPENDENT SCHOOL DISTRICT
EMPLOYEE ACCIDENT OR WORK-RELATED ILLNESS REPORT

PART-I
(TO BE COMPLETED BY EMPLOYEE WITHIN 24 HRS)

DATE OF THIS REPORT: _____ Circle One: **RECORD ONLY** **MEDICAL**

EMPLOYEE NAME: _____ Date of Birth: _____ Home Phone#_____

SOCIAL SECURITY NO.:_____ Does Employee Speak English? (Circle one) Yes No

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Marital Status: (circle one) ☐Single ☐Married ☐Divorced ☐Widowed ☐Male ☐Female ____Dependents

DATE OF INJURY: _____ TIME OF INJURY: _____ a.m. /p.m.

Name of person accident reported to: _____ Date reported: _____

Name of Campus/Location: _____Address: _____

Employee began work at _____ a.m. /p.m. Supervisor: _____ Phone#: _____

Dept. regularly employed in _____ Occupation when injured _____

Employee: ☐Full Time ☐Part Time ☐Substitute Employee doing regular duties? ☐Yes ☐No

Worksite location of injury (*stairs, dock, hallway, parking lot, etc*.): _____

Describe fully how accident occurred: _____

_____

Part of body injured/affected (indicate left/right and/or upper/lower):_____

Name of Witness: _____

Name, address and phone # of physician (only if medical attention is required): _____

_____

_____ _____

EMPLOYEE SIGNATURE DATE ADMINISTRATIVE SIGNATURE DATE

OFFICE USE ONLY

Last Paycheck Amt: _____ Pay Rate: Daily/Hourly _____ Weekly/Monthly _____ Full/Part Time

Dept. Code _____ Job Class Code: _____ Loc Code: _____ Calendar: _____ Hire Date: _____

PART – II

OFFICE USE ONLY

ADMINISTRATOR TO COMPLETE: (To be completed within 48 hours)

Cause(s) of Accident: _____

_____

Corrective Actions Needed _____

_____

Sick Leave Election (circle one) yes/no Days Absent _____ Date returned to work: _____

Work Status Report submitted: Date _____ Rights & Responsibilities Booklet Date _____

_____ _____

Administrative Signature Date