Lincoln County Schools Internal Accident Report 7.1.12

Date of Accident: ___/___/___Time of Accident: _____ Time Reported to work:_____

Employee Name: _____ Marital Status:_____

Employee Phone Number: (____) -_____ - _____ Birth Date: ____/____/____

Employee Job Classification: _____ Location_____

Did Injury Occur on Employer's Property? ( ) yes ( ) no Location where injury occurred: _____

What was the Employee Doing when Injury Occurred (loading truck, walking down stairs, be specific):

_____
_____
_____
_____
_____

Supervisor to whom Injury was reported to:_____
Did employee have to leave work? ( ) yes ( ) no If so what time?_____
Did employee seek medical treatment? ( ) yes ( ) no Doctor_____
Was employee transported to an emergency care facility? ( ) yes ( ) no.

Type of Accident	*Type of Injury*	*Accident Location*	*Injury Location*
( ) Electrical	( ) Abrasion ( ) Amputation	( ) Kitchen	( ) Head
( ) Hand Tools	( ) Burn ( ) Bruise	( ) Maintenance	( ) Neck
( ) Transportation	( ) Foreign Object ( ) Fracture	( ) Bus Garage	( ) Back
( ) Machinery	( ) Laceration ( ) Puncture	( ) Stairs	( ) Torso
( ) Lifting/Carrying	( ) Sprain ( ) Strain	( ) Hallway	
( ) Slip/Trip/Fall	( ) Other – Specify: Right/Left	( ) Office	( ) L *or* ( ) R
( ) Other – Specify:	_____	( ) Classroom	( ) Arm
_____	_____	( ) Gym/Athletic Field	( ) Leg
_____	_____	( ) Other – Specify:	( ) Eye
_____	_____	_____	( ) Foot/Ankle
			( ) Hand/Wrist

Have you had Prior Injury to this body part? ( ) Yes ( ) No

Name any Witnesses to the Accident/Injury:
_____ Phone _____
_____ Phone _____

_____ Date _____/_____/_____
Principal

_____ Date _____/_____/_____
Employee

THIS REPORT TO BE COMPLETED WITHIN 24 HOURS OF THE ACCIDENT AND FORWARDED TO TRINA BARRETT VIA FAX AT 304-824-7947.