

**ST. JAMES R-I SCHOOL DISTRICT**  
**EMPLOYEE ACCIDENT/INCIDENT REPORT FORM**

EMPLOYEE NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

DATE OF ACCIDENT/INCIDENT: \_\_\_\_\_ TIME: \_\_\_\_\_

SUPERVISOR NAME: \_\_\_\_\_ BUILDING: \_\_\_\_\_

OTHER EMPLOYEE(S) PRESENT: \_\_\_\_\_

Describe Nature of Accident/Incident (include location of accident; activity engaged in; other pertinent information): \_\_\_\_\_

\_\_\_\_\_

Describe Specific Injury Sustained (include specific body part injured): \_\_\_\_\_

\_\_\_\_\_

Describe Initial Course of Action (first aid, ambulance contacted, family member contacted, police contacted, etc.): \_\_\_\_\_

\_\_\_\_\_

Nurse/Administrator/Supervisor Response: \_\_\_\_\_

\_\_\_\_\_

Recommendation for Prevention of Another Occurrence: \_\_\_\_\_

\_\_\_\_\_

**COPIES TO: Nurse's Office,  
Superintendent's Office,  
Principal's Office, and  
Building/Grounds Coordinator's Office**

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

\_\_\_\_\_  
Date

Superintendent's Initial: \_\_\_\_\_

\_\_\_\_\_  
Signature of Principal

FOR CENTRAL OFFICE USE ONLY

Employee SSN \_\_\_\_\_ Employee Hire Date \_\_\_\_\_ Rate of Pay \_\_\_\_\_

Marital Status \_\_\_\_\_ # of Dependents \_\_\_\_\_ Employee Position \_\_\_\_\_

Employee Address: \_\_\_\_\_ Employee Phone: \_\_\_\_\_

Date & Time Reported to Central Office \_\_\_\_\_ Date Reported to Workman's Compensation: \_\_\_\_\_

Workman's Compensation Report Number: \_\_\_\_\_

Referral to Clinic \_\_\_\_\_ Hospital \_\_\_\_\_ No further action \_\_\_\_\_

Additional Notes: \_\_\_\_\_

\_\_\_\_\_

Reported by: \_\_\_\_\_