

EMPLOYEE ACCIDENT/INCIDENT REPORT

All Fields are required to be completed.

Please Select Your School Division & Location:			
School Board:	<input type="text" value="Pembina Trails School Division"/>		
School Name:	<input type="text"/>		
Phone #:	<input type="text" value="204 -"/>		
First name of injured person:			
<input type="text"/>			
Last name of injured person:			
<input type="text"/>			
Job title of injured person:			
<input type="text"/>			
Date of birth:	Month:	Day:	Year:
<input type="text"/>			
Address:			
<input type="text"/>			
City/Province:			
<input type="text"/>			
Postal Code:			
<input type="text"/>			
Telephone #:	<input type="text" value="204 -"/>		
Date of accident:			
<input type="text" value="Month: Day: Year:"/>			
Time of accident:			
<input type="text" value="Hour: Minute: AM / PM:"/>			
Where did the accident occur? If other, please specify.			
<input type="text" value="IA Class"/> <input type="text" value="Home Ec. Class"/> <input type="text" value="Classroom"/> <input type="text" value="Laboratory"/> <input type="text" value="Playground"/> <input type="text" value="Field Trip"/> <input type="text" value="Bus"/> <input type="text" value="Phys. Ed. – Outside"/> <input type="text" value="Phys. Ed. – Inside"/> <input type="text" value="Other: _____"/>			
Describe in detail how accident occurred:			
<div style="border: 1px solid black; height: 150px;"></div>			

EMPLOYEE ACCIDENT/INCIDENT REPORT

Guidelines on classification of accident/injuries (Check One):

- "MINOR" - Scratch, Bruise, Scrape, Minor Cut, Minor Sprain, etc.
- "MODERATE" - Serious Cut, More Severe Sprain, Broken Finger, etc.
- "SEVERE" - Injury to Eye, Face, Back, Broken Arm/Leg, etc.
- "NEAR MISS"

Exact nature and type of injury: Circle all that apply. If other, please specify.

Nature of injury: cut break crush poke burn hit fall concussion amputation

other: _____

Type of injury (Body Part): arm leg head/face chest hip back (upper/lower) hand foot

finger toe other: _____

Where on the body: left right Not applicable

Was injury treated (circle one):

Yes No Not Known Other: _____

Additional comments:
 (type of treatment)

Name of witness(es):

- 1.
- 2.
- 3.

Any additional comments:
 (Details of hospital, x-ray, etc.)

Name of principal/supervisor
 (in full):

Submitted by:

Email:

Date Submitted:

Day: Month: Year: