Abingdon-Avon CUSD #276
Injury / Accident Report Form
Information for *EMPLOYEE/VISITOR* injuries

*Employee ☐ Vendor ☐ Visitor/Customer ☐ Date: _____

Injured Party: _____ Address: _____ Phone: _____

Sex: M ☐ F ☐ Age: _____ Date of Accident: _____

Time of accident: _____ AM ☐ PM ☐ Place of Accident: _____

Location of Accident: _____

*(If injured is an employee, a Form 45 must still be completed.)

Cause of Injury

Bodily Reaction	☐	Lifting	☐
Caught In	☐	Overexertion	☐
Chemical Contact	☐	Rep Motion	☐
Exposure	☐	Fall (elevation)	☐
Struck by	☐	Slip/trip/fall	☐
Struck on	☐	Heat Contact	☐

Other: _____

Type of Injury

Bee sting	☐	Fracture	☐
Bite	☐	Hernia	☐
Burn (chem)	☐	Laceration	☐
Burn (heat)	☐	Multiple	☐
Chemical	☐	Occptnl Illness	☐
Contusion	☐	Puncture	☐
Crush	☐	Rash	☐
Cum Trauma	☐	Sprain (ligmt)	☐
Death	☐	Strain (musc)	☐
Foreign Object	☐	Stress	☐

Other: _____

Description of the Injury

How did the injury happen? _____

What was injured person doing? _____

List specifically unsafe acts or conditions. _____

Specify any tool, machine, or equipment involved. _____

Part of Body

Arm	☐	Back	☐	Eye	☐	Foot	☐	Ankle	☐	Mental	☐	Torso/Trunk	☐
Groin	☐	Head/Face	☐	Internal	☐	Knee	☐	Leg	☐	Respiratory	☐	Wrist/hand	☐

Other: _____

Immediate Action Taken

First-aid treatment ☐ By (Name): _____

Sent to physician ☐ By (Name): _____
Physician's Name: _____

Sent to hospital ☐ By (Name): _____
Name of Hospital: _____

Witnesses

1. Name: _____ Addresses: _____ Phone: _____
2. Name: _____ Addresses: _____ Phone: _____

What suggestion do you have for preventing other accidents of this type?

Signatures

Manager: _____ Date: _____

Employee: _____ Date: _____

Submit to District Office (within 24 hours)