Employee Accident Information Form

Pikeland CUSD #10
PO Box 515
Pittsfield, IL 62363

Date of Report: _____

Note: Supervisor to fill out form

Employee Information

Name: _____

Address: _____
(Street)

_____
(City) (State) (Zip)

Home Phone #: _____ Cell Phone #: _____

Email address: _____

Date of Birth: _____ Gender: Male _____/Female _____

Marital Status: Married _____/Single _____

Family/Emergency Contact: _____
(Name) (Phone)

Employment Information

Date of Hire: _____

Job Classification: _____

Accident/Injury Information

Date of Accident: _____ Time of Accident: _____

Where did the accident happen?

Address: _____
(Street) (City) (State) (Zip)

How did the accident/injury happen? Please describe.

_____

_____

_____

_____

What was the injury? List the part of the body affected.

_____

_____

Any previous injury to the same body part? _____

_____

Witnesses: (1)_____
(Name) (Address)

_____
(City) (State) (Zip) (Phone)

(2) _____
(Name) (Address)

_____
(City) (State) (Zip) (Phone)

When was the injury/accident first reported: _____

Who was the injury/accident reported to? _____

Any lost workdays? _____NO _____YES If yes how many?_____

If treatment was given away from the worksite, list the names and address of the place it was given:_____

EMPLOYEE SIGNATURE: _____DATE: _____

REPORTING SUPERVISOR: _____DATE: _____

Office use only

Received by:_____Date:_____

IL FORM 45 completed:_____Date mailed:_____