

Reagan County Independent School District
Employee Accident Report

Employee Section:

Employee: _____ Date of Accident: _____

Job Title: _____ Social Security # _____

Address: _____ Spouse: _____

Marital Status _____ # of Dependents _____

Hire Date: _____ Telephone # _____

Accident Description (Location, time, people involved, etc.):

Description of injury and/or property damage:

Medical Treatment Sought ? **Y N** By: _____

Employee Signature

Date

Supervisor Section:

Conditions or Causes of Accident:

Recommended Corrective Actions:

Supervisor Signature

Date

Central Office Section:

Rate of Pay: _____ per _____ Months _____ Years _____ worked

Last paid \$ _____ for _____ as _____