CENTRAL COMMUNITY SCHOOL SYSTEM

10510 Joor Road, Suite 300 Central, LA 70818

EMPLOYEE ACCIDENT REPORT

All questions must be answered completely:

Location: _____ Date: _____

Name: _____ Social Security #: _____

Last First

Address: _____

street City State Zip Code

Home Telephone #: _____ Work Telephone #: _____

Date of Birth: _____ Age _____

Date of Accident: _____ Time of Accident: _____ a.m./p.m.

Working shift from: _____ a.m./p.m. to: _____ a.m./p.m.

Days off: M T W TH F (Circle)

Location of Accident (by area): _____

Supervisor's Name: _____

Witness: 1) _____ 2) _____

3) _____ 4) _____

Describe accident in detail (*How did the accident occur? Be specific*):

(Please use the back of this form if you need additional room to describe the accident)

Nature of injury and parts of the body injured: _____

_____ _____

Employee Signature Date