# Woodridge Local School District

## EMPLOYEE REPORT OF ACCIDENTAL INJURY

Employee's Name:_____

Home Address:_____

Date of Injury:_____ Hour: _____ a.m. _____ p.m.

Occupation:_____

Description of how injury occurred:_____

_____

_____

Did injury occur on school premises? Yes _____ No _____

If yes, specify:_____

If no, where?_____

Days absent due to injury:_____

Date returned to work:_____

Names & addresses of witnesses:_____

_____

_____

Name of hospital and/or physician:_____

_____

Has Bureau of Workmen's Compensation claim form been filed? Yes _____ No _____

If yes, Date the form was filed:_____

Name of person you notified of the injury/accident:_____

Date (notified):_____ Time (notified):_____

_____ _____
Principal Signature Signature of Employee

_____ _____
Supervisor Signature Date

NOTE: When Completed, Please return to the Board Office (Attention: Darlene Neel)

1/02
9/02