GENESEO COMMUNITY UNIT SCHOOL DISTRICT #228
WORKMEN'S COMPENSATION
EMPLOYEE ACCIDENT REPORT

Today's Date _____

Name _____ Social Security # _____

Address _____ Birthdate _____ Gender: M F

_____ Phone# _____

Accident Time & Location

Date: _____ Time: _____ Location: (State exactly where accident occurred.)

_____

Accident

What was the employee doing when injured? _____

_____

Describe how the accident occurred. _____

_____

Injury

Describe the injury. _____

Was a District School Nurse notified? **Yes** **No**

Was an ambulance called? **Yes** **No**

Was the employee excused from work for medical attention? **Yes** **No**

Type of medical attention received. _____

Name of physician who provided medical treatment. _____

Name of institution where treatment was received. _____

Was an x ray taken? **Yes** **No** If yes, where was it taken? _____

Include the dates of the days the employee missed of work due to injury. _____

_____

_____ _____

Signature of Employee Signature of Principal

Claim Filed _____ (Office Use Only)