OAKRIDGE PUBLIC SCHOOLS

REPORT OF ACCIDENT FORM

IF POSSIBLE, TO BE FILLED OUT IN INJURED EMPLOYEE'S OWN HAND-WRITING AND TURNED IN TO THE CENTRAL OFFICE AS SOON AS POSSIBLE.

Name _____ Age _____ Birthdate_____

Address _____

City/Zip Code _____Phone _____

Marital Status: Married Unmarried Separated

Date of Injury _____ Time of Injury _____

Date reported _____ To whom was it reported? _____

Explanation of injury _____

_____

_____

Where did it happen? _____

_____

How did it happen? _____

_____

Person in Charge/Supervisor _____

Witnesses _____

Did you go to the doctor? _____ If yes, name _____

Did you go to hospital or Medi-Center? _____ If yes, name _____

□ Medical treatment refused on date of injury. I understand I may, within a reasonable period of time, request medical treatment by contacting the Worker's Comp Coordinator.

Signed _____ Date _____

Revised: 06/2014