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USD 489 – HEALTH SERVICES
EMPLOYEE ACCIDENT REPORT FORM

Name of Employee _____ Age _____ Sex _____
First Middle Last

Home Address _____ ZIP _____

SS # _____ Birthdate _____ Home Phone _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widow/Widower

Employee's Occupation _____ Working Hours/Day _____

Date of Injury _____ Time of Injury _____ A.M. P.M.

Place of Accident _____ First Date of Disability _____

How did the accident occur and what was the cause? _____

_____

What was the employee doing when injured? _____

_____

Name of substance or object that directly caused injury? _____

Describe in detail the nature and extent of injury, and **indicate part(s) of body** involved _____

_____

_____

What could be done to prevent this type of accident from happening again? _____

_____

Name of witness to the accident _____

Was employee admitted to hospital? _____ Date _____ Emergency Room only _____

Hospital and address _____

Name and address of attending physician _____

_____

Have you returned to work? Yes ____ No ____ If so, give date _____

I verify the above information is correct to the best of my knowledge.

_____
Signature of Employee Date

_____
Signature of Principal/Supervisor Date

_____
Signature of person who reviews accident report Date

DO NOT WRITE IN THIS SPACE

File No. _____

Weekly Salary_____

Date of Hire _____

Years in Current Position _____

Return Form to: Human Resources · RAC · 323 West 12th Street · Hays, Kansas 67601 · (785) 623 2400