Provo City School District

Policy Series 5000: Personnel

5120 F4

Employee Accident Information Form

EMPLOYEE

Name (Last, First Middle) Address (Incl. Zip)	Date of Birth	Social Security Number		Date Hired	State of Hire
	Sex ☐ Male ☐ Female	Marital Status ☐ Unmarried / Single / Divorced ☐ Married ☐ Separated		Job Title	
Claimant may need an Interpreter: ☐ Yes ☐ No Language _____					
Phone	Number of Dependents			Employment Status	

WAGE

Rate $ _____ ☐ Day ☐ Month Per: ☐ Week ☐ Other	Number of Days Worked/Week	Full Pay for Day of Injury ☐ Yes ☐ No Did Salary Continue ☐ Yes ☐ No

OCCURRENCE

Time Employee Began Work ☐ AM ☐ PM	Date of Injury/Illness	Time of Occurrence ☐ AM ☐ PM	Last Day Worked	Date Employer Notified	Date Disability Began
Did Injury/Illness Exposure Occur on Employer's Premises? ☐ Yes ☐ No		Type of Injury/Illness		Part of Body Affected	
Department Or Location Where Accident or Illness Exposure Occurred		All Equipment, Materials, Or Chemicals Employee Was Using When Accident Or Illness Exposure Occurred			
Specific Activity The Employee Was Engaged In When The Accident Or Illness Exposure Occurred		Work Process the Employee was Engaged In When Accident or Illness Exposure Occurred			
How Injury or Illness / Abnormal Health Condition Occurred, Describe the Sequence of Events and Include Objects or Substances that Directly Injured the Employee or Made The Employee Ill.					
Date Return(ed) to Work	If Fatal, Give Date of Death	Were Safeguards Or Safety Equipment Provided? ☐Yes ☐ No Were Safeguards Used? ☐Yes ☐ No			
Physician/Health Care Provider (Name & Address)	Hospital (Name & Address)	Initial Treatment ☐ No Medical Treatment ☐ Minor: By Employer ☐ Minor: Clinic/Hospital ☐ Emergency Care ☐Future Major Medical / Lost Time Anticipated			