EMPLOYEE ACCIDENT REPORT

TEXAS CITY INDEPENDENT SCHOOL DISTRICT

White: Human Resources **Yellow: Supervisor's File** **Pink: Employee**

Name: (last, first MI)		**Sex: (MorF)**		**Ethnicity: (black, hispanic, white, other)**	
Social Security #:		**Home phone:**		**Date of Birth:**	
Occupation:		**Years at position:**		**Years in occupation:**	
Mailing Address:					
City, State, Zip, County:					
Marital Status: (married, single, separated, divorced or widowed)		**# Dependent Children:**		**Spouse's Name:**	
Date of Injury: (mo-day-year)		**Time of Injury:**		**am: ☐ pm: ☐** **Date Lost Time Began:**	
Nature of Injury:		**Part(s) of Body Affected:**			
How/why Accident Occurred:					
Injury cause:		**Accident Location:**		**Accident Address:**	
Witnesses:					
Nurse/First Provider:					
Nurse/First Provider Recommendations:					
Doctor Name: (if needed)		**Doctor Address:**			
Doctor City:		**Return to work date: (or expected)**			
Corrective Action(s):					
Supervisor Signature:				**Date Reported:**	
Employee Signature:					