



5207 S. Montana Avenue, Caldwell, ID 83607
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EMPLOYEE'S ACCIDENT/ILLNESS REPORT FORM

Please complete this form in its entirety the same day of an accident that results in an injury. Forward this report to your school principal or supervisor, who will forward report to the DO/ Safety Coordinator along with the Supervisor's Report.

INFORMATION REQUIRED BY STATE INSURANCE FUND	
NAME OF INJURED / ILL WORKER:	
ADDRESS:	
CITY/STATE/ZIP:	
PHONE #:	SOCIAL SECURITY #:
BIRTH DATE:	HIRE DATE:
MARITAL STATUS:	# OF DEPENDENTS:
JOB POSITION:	
SCHOOL SITE ASSIGNED:	

ACCIDENT/INJURY INFORMATION	
DATE OF ACCIDENT OR ONSET OF ILLNESS:	TIME ACCIDENT OCCURRED:
ACCIDENT/ILLNESS LOCATION:	TIME EMPLOYEE BEGAN WORK:
WITNESSES:	
DESCRIBE ILLNESS/INJURY IN DETAIL (including location of accident, cause, part of body affected, etc.):	
Body part injured before? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain: Pre-existing condition(s)?	
MEDICAL ATTENTION NEEDED? <input type="checkbox"/> Yes, treatment was needed (self-care, non-professional) <input type="checkbox"/> No, treatment not needed at this time	<input type="checkbox"/> Yes, treatment was needed by a doctor If yes, give caregiver's name and address:

INJURED/ILL PERSON'S SIGNATURE:	DATE:
PRINCIPAL/SUPERVISOR'S SIGNATURE:	DATE: