

# Idaho Falls School District #91 Employee Injury Accident Report

- **FILL IN ALL BLANKS *WITHIN THE SHIFT OF THE INJURY* SUPERVISOR, AND EMPLOYEE MUST SIGN.**
- **IF MEDICAL CARE BEYOND FIRST AID, GO TO Ammon Medical & Urgent Care.**

Name of Employee \_\_\_\_\_

Home Address \_\_\_\_\_ Zip \_\_\_\_\_ Phone Number \_\_\_\_\_

Injury Date \_\_\_\_\_ Date Supervisor Notified \_\_\_\_\_ Job Title \_\_\_\_\_

Location where injury occurred-be specific: Building/School \_\_\_\_\_ Room \_\_\_\_\_

Time Accident Occurred \_\_\_\_\_ Time Work Began \_\_\_\_\_

Description of how the accident occurred? (Job being done, tools, people, objects involved (use back if needed))

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Type of Injury \_\_\_\_\_ Part/s of Body \_\_\_\_\_  
(Strain, bite, bruise, cut, etc.) (Right calf, left big toe, left forearm, etc)

Names of Witnesses who saw the accident happen: \_\_\_\_\_

Has this part of your body been injured before? \_\_\_\_\_ Date \_\_\_\_\_ Place \_\_\_\_\_

Were you using safety equipment provided? \_\_\_\_ Was accident caused by non-employee or faulty equipment? \_\_\_\_

**Is medical treatment necessary?  Yes  No**  
**Call HR at 208-525-7500 then proceed to the clinic listed below.**

**Ammon Medical & Urgent Care – 3456 E 17<sup>th</sup> St. Suite 125, Ammon, ID**  
**DELIVER ALL MEDICAL PAPERWORK TO HR IMMEDIATELY**

**Signature of agreement: Report is correct and true as reported, and filled in during the shift of injury/accident:**

Employee's Signature \_\_\_\_\_ Today's Date \_\_\_\_\_

Supervisor's Signature \_\_\_\_\_ Today's Date \_\_\_\_\_