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 occured? (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? Call or Text HR at 208-569-3574 then proceed the clinic listed below.

Ammon Medical & Urgent Care – 3456 E 17th St. Suite 125, Ammon, ID
TEXT/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** _____

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