HENRY-STARK COUNTIES SPECIAL EDUCATION DISTRICT #801

1318 W. Sixth Street
PO Box 597
Kewanee, IL 61443
Phone: (309) 852-5696
Fax: (309) 853-4398

Employee Accident and Injury Investigation Form

Following all accidents or injuries on the job, employee must report the incident immediately to the supervisor. Within 24 hours, this form must be completed by the immediate supervisor and forwarded to the HSCSED Admin Office.

To be completed by the immediate supervisor only (NOT THE EMPLOYEE).

Employer Information

Employer Name: Henry-Stark Counties Special Education District #801
City, State, Zip: Kewanee, IL 61443
HR Manager: Candace Wexell
Director: T. Gregory Wertheim

Employee Information

Name:
Last_____
First _____
Middle_____
Date of Birth: _____
SSN: _____
Address: _____
City: _____
State: _____
Zip: _____
Gender: Male or Female
Phone: _____
Email Address: _____
Marital Status: Single, Married, Divorced, or Widowed
Number of Dependents: _____
Occupation: _____

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Accident Information

Accident Date: _____
Accident Time: _____AM or PM
Time Employee Began Work: _____AM or PM
Last Date Employee Worked: _____
Name of Location Where Accident Occurred: _____
Address of Accident: _____
Accident City: _____
Accident State: _____
Accident Zip Code: _____
Did Employee Die Due to Incident: Yes or No
Employee Date of Death: _____
Did Accident Occur on the Employer's Premises: Yes or No
What was the Employee Doing when the Accident Occurred? _____
_____
_____
_____
How did the Accident Occur? _____
_____
_____
_____
Nature of Injury Description: _____
Affected Body Part: _____
Object/Substance that Caused Harm: _____
Were Medical Services Rendered? Yes or No
Name of Family Physician/Healthcare Professional:
Last_____
First_____
Name of Family Physician/Healthcare Group: _____
Address of Physician/Healthcare Professional: _____
Physician/Healthcare Professional City: _____
Physician/Healthcare Professional State: _____
Physician/Healthcare Professional Zip Code: _____
Was treatment was given away from the worksite? Yes or No
Name of Treatment Facility: _____
Name of Doctor Rendering Services:
Last_____
First_____
Treatment Address: _____
Treatment City: _____
Treatment State: _____
Treatment Zip Code: _____
Treated in Emergency Room? Yes or No
Was the Employee Hospitalized Overnight as an Inpatient: Yes or No

Signature of Investigator (Supervisor):_____Date:_____

Signature of Injured Worker:_____Date:_____