

Yreka Union High School District
400 Preece Way – Yreka, California 96097

EMPLOYEE REPORT OF ACCIDENT
(REPORT INJURY WITHIN 24 HOURS OF OCCURANCE)

NAME _____

DATE OF INJURY _____ TIME OF INJURY _____ (am/pm)

PART OF BODY INJURED (LEFT/RIGHT) _____

LOCATION OF ACCIDENT _____

LIST WITNESSES _____

DESCRIPTION OF HOW INJURY OCCURRED _____

WAS MEDICAL TREATMENT NEEDED: ___ YES ___ NO

IF YES, LIST NAME AND ADDRESS OF DOCTOR OR HOSPITAL WHERE MEDICAL TREATMENT WAS
RECEIVED: _____

NAME OF SUPERVISOR NOTIFIED _____ DATE _____

NAME OF PERSON COMPLETING THIS FORM _____ DATE _____