Seminole Independent School District Work Related Injury Report (Please Print or Type)

Injured Employee's Name		
Social Security Number		
Mailing Address		
Telephone Number		
Date of Birth	9	
Sex Marital	Status	
Spouse's Name	Home_	
-		
Position		
Is this a regular duty	Number of hours worked per da	ny
Date of Injury		
Day of Week	Time of Day	A.M. / P.M.
Where did accident occur? (i.e. student park	ring lot at high school)	
Describe how accident occurred and what en	mployee was doing when injured?	
Describe part of body affected – Be specific		
Name of witnesses:		
Foreman / Supervisor		
Date and Time foreman first knew of injury_		
Foreman / Supervisor's Signature	Date	
Did injured go to the doctor and / or hospita	19	
If ves. name of doctor / hospital		
Address		
Did injured leave work?		
Address		
Date of this report		
REPORT OF INJURY SHOULD BE TURN DAY OF INJURY.	NED IN TO BUSINESS OFFICE WITHI	IN ONE WORK
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Date received by Business Office		