San Leandro Unified School District
835 E. 14th Street Suite 200 ◆ San Leandro, CA 94577
(510) 667-0537 FAX (510) 667-6234

Employee Accident Report

Name_____ PSL#_____ Classified ❑ Certificated ❑

Home Address _____

Sex: M ❑ F ❑ Birth Date: _____ Employment: Full-time ❑ Part-time ❑ Time in present position: _____

Job Title: _____ Site: _____

Supervisor: _____ Phone: _____

Accident Date: _____ Time: _____ Location: _____

Describe what happened, what you were doing when the accident occurred and what you were using (tools, equipment, etc.)._____

_____

Was this part of your normal job duty? Yes ❑ No ❑ **Will you seek treatment for this injury?** Yes ❑ No ❑

What part of the body was affected or injured_____

Any witnesses? Yes ❑ NO ❑ Name:_____ Phone: _____

Report prepared by (if different from injured employee):_____ Phone: _____

Employee Signature: _____ Date: _____

RETURN THIS FORM TO THE EMPLOYEE BENEFIT SPECIALIST AT DISTRICT OFFICE

Supervisor/ Person in Charge

This accident was reported to me on Date: _____ at Time: _____

Is further investigation required? Yes ❑ No ❑ Will follow up on Date: _____

Supervisor/Person in Charge (please print) Name: _____ Position: _____

Signature: _____ Date: _____

THIS REPORT IN NOT APPLICABLE TO WORKERS COMPENSATION BENEFITS