EDUCATIONAL SERVICE UNIT ONE
211 TENTH STREET
WAKEFIELD, NE 68784
PHONE: (402) 287-2061 FAX: (402) 287-2065
www.esu1.org

Accident Report

Injured Employee: _____ SSN: _____

Address: _____

Sex: ☐ Male ☐ Female Marital Status: _____ # of Dependents: _____ DOB:_____

Date/Time of Injury: _____/_____/_____ _____ A.M./P.M.

Date/Time reported to ESU #1: _____/_____/_____ _____ A.M./P.M.

Job Title: _____ Location: _____ How Long In Position: _____

Time work day began: _____ A.M./P.M.

Accident Location (i.e. building, room, etc.): _____

Object that injured employee: _____

What was employee doing when injury occurred?

How did accident/injury occur?

Describe injury in detail and part of body affected:

Individual(s) who witnessed accident: _____

Has injured employee returned to work? ☐ Yes ☐ No

Was First Aid provided: ☐ Yes ☐ No

If YES, by whom? _____

What First Aid treatment was given: _____

Date/Time this report was completed: _____/_____/_____ _____ A.M./P.M.

_____ _____

Employee Signature ESU #1 Supervisor Signature

OFFICE USE ONLY:

Wage: $_____ ☐ Daily ☐ Monthly

Hire Date: _____ Employment Status: ☐ Full-Time ☐ Part-Time

Hours Worked Per Day _____ Hours Per Week _____ Days Per Week _____

Did employee receive medical authorization form? ☐ Yes ☐ No

Submit completed copy to ESU #1 Central Office Personnel.

Clear Data