



Temple ISD

Nurse's Report of Employee Accident, Injury, or Illness

Instructions: Please Print. Fill in all blanks. If a blank does not pertain to the accident, injury, or illness, write "NA" in the blank. Complete Immediately. Keep a copy and send the completed original form to Amy Hayes, Director of Wellness and Benefits in the Human Resources Department.

Name of Employee: _____

Date & Time of accident, injury, or illness:		Employee Benefit Department Notified <input type="checkbox"/> YES <input type="checkbox"/> NO Name: _____	
Location of accident, injury or illness (<i>Name of Campus or other facility</i>):			
Worksite location: (<i>stairs, classroom, kitchen etc.</i>)		Who did you notify about accident, injury or illness?	
What was the cause of the accident, injury or illness?			
What could have prevented the accident, injury or illness?			
Describe Accident ,Injury or illness if you witnessed it:			
Name(s) of Witness (<i>if applicable</i>):		Name of Employee's Supervisor:	
Type of injury or Illness: (<i>cut, sprain, fall, fumes etc.</i>)		Area of body effected:	
Did Nurse provide treatment?: <input type="checkbox"/> YES <input type="checkbox"/> NO		Date & Time of Treatment:	
Describe Treatment Provided:			
Did Employee seek further medical evaluation? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, Where did employee seek care and How did Employee travel to medical facility:			

The information I have provided either in my own writing or verbally for the purpose of reporting the events of this accident, injury or illness is true and correct. I understand that providing false or misleading information or omission of information on this report or any other form relating to this claim of accident, injury or illness may result in termination of my employment.

Signature of nurse Date