

**HAMPSHIRE COUNTY BOARD OF EDUCATION
UNUSUAL INCIDENT OR ACCIDENT REPORT FORM FOR EMPLOYEES**

The Finance Office **MUST** be notified **IMMEDIATELY** by telephone and/or EMAIL -- this form **MUST** be completed and emailed to Rhonda.Baker@K12.wv.us **AND** DHott@K12.wv.us on the **SAME DAY** of the incident (We only have **24 HOURS** to report these claims!!)

| | | |
|-------------|--|-------------------------|
| WHEN | Date of Incident | Time of Incident |
| | Was Incident reported immediately to supervisor? | If not, please explain: |

| | | |
|------------|-----------------------|-------------------------------------|
| WHO | Employee Name | Job Title |
| | Primary Work Location | Date of Birth |
| | Address | Phone Number |
| | Marital Status | Gender |
| | Names of Witnesses | Time began work on date of incident |

| | | |
|---|--|--|
| INJURY | Describe how the incident occurred (specifically the cause, what you were doing, and equipment/objects involved) | |
| | Nature / Extent of injuries (include body part injured and state L or R if applicable): | |
| | Exact location where the incident occurred: | |
| | Was first aid Administered? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | If yes, please explain | |
| | Did you /will you see a doctor about your injury? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | Doctor's Name | Doctor's Phone Number |
| | Did employee leave work | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| If yes, date and time returned to work: | | |

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| | | |
|---------------|--|--|
| CAUSES | Direct Cause of Injury (explain event that directly caused incident) | Was a third party involved? |
| | | Was equipment involved in or cause the incident? |

| | |
|--------------------|---|
| SUGGESTIONS | What could have been done to prevent this injury? |
| | Any additional comments |

| | | |
|-------------------|---|------|
| SIGNATURES | Employee Signature | Date |
| | Supervisor's Signature | Date |
| | Nurse Signature (if first aid administered) | Date |
| | Witness Signature(s) (if available at time of submitting) | Date |

| | | |
|------------------------|---------------------|-----------------------|
| OFFICE USE ONLY | DATE OF HIRE | DAILY RATE OF PAY |
| | SS NUMBER | POLICY NUMBER |
| | ADDITIONAL COMMENTS | HOURS WORKED PER WEEK |