

**LOS MOLINOS UNIFIED SCHOOL DISTRICT
EMPLOYEE ACCIDENT/INCIDENT REPORT**

Employee Name: _____ Job Title: _____
Work Site: _____ Date of Incident: _____
Location of Incident: _____ Time of Incident: _____
Incident Reported to: _____ Date Reported: _____

INCIDENT INFORMATION

Describe what happened:

Body part(s) affected, if applicable: _____

Were there witnesses? ☐ No ☐ Yes Witness Name(s): _____

IMMEDIATE RESPONSE

Was first aid provided? ☐ No ☐ Yes

If yes, briefly describe: _____

Did the employee leave work because of incident? ☐ No ☐ Yes

Did the employee request or seek medical treatment? ☐ No ☐ Yes

Is the employee experiencing continuing symptoms? ☐ No ☐ Yes

If yes, briefly describe: _____

ACKNOWLEDGEMENTS

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

SUBMIT COMPLETED FORM TO CHRISTIE LANDINGHAM AT THE DISTRICT OFFICE

NOTICE: This form is for internal District reporting purposes only and is not a Workers' Compensation Claim Form (DWC-1). Completion of this form does not replace or affect an employee's right to report a work-related injury or file a workers' compensation claim. Workers' compensation forms and information will be provided when applicable.