Montoursville Area School District
Employee Incident Report Form

EMPLOYEE INFORMATION:					
Employee Completes This Section					
Work Location:					
Employee's Name (PRINT):				☐ Male	☐ Female
Home Address:			City, State:		Zip:
Home Phone:			Work Phone:		
Job Title:					
Work Hours:			Hours Worked per Week:		
Employment Type:	☐ Full-time	☐ Part-time	☐ Volunteer		
Do you have other employment:		☐ Yes	☐ No	If Yes, where:	

INCIDENT INFORMATION			
Date of Incident:		Time of Incident:	☐ a.m. ☐ p.m.
Location of Incident: (circle one)	*LOYALSOCK VALLEY*	If "other", please specify:	
	LYTER		
	C.E. MCCALL		
	MONTOURSVILLE HIGH SCHOOL		
	DISTRICT OFFICE		
	OTHER		
State all parts of body and type of injuries involved (e.g. bruised right elbow):			
Describe how incident occurred:			
Was incident reported to Supervisor?	☐ Yes Date(s)_____	☐ No	If "yes" to whom:
Any prior injuries to injured area?	☐ Yes Date(s)_____	☐ No	If "yes" please describe:
Were there witnesses?	☐ Yes ☐ No	☐ Unknown	
Name of Witness #1 (First and Last):			
Witness #1 Phone:			
Name of Witness #2 (First and Last):			
Witness #2 Phone:			
Is this a new injury?	☐ Yes ☐ No	If "no", please indicate the date of original injury:	

INITIAL MEDICAL TEATMENT:				
Was treatment received for this injury?				
☐ No medical treatment – reporting only		☐ Declining treatment at this time		☐ Treatment was/will be provided
Treatment was provided by:	☐ Self	☐ School Nurse	☐ Emergency Room	☐ Other
If treatment was provided by someone other than self or school nurse please list name and location of medical provider:				
Name:			Phone:	
Address:				
I, the injured employee, herein certify the information above is true and to best of my knowledge.				
Date:		Signature of Employee:		

After completing medical treatment please forward form to the building supervisor

SUPERVISOR COMPLETES THIS SECTION:					
Supervisor Name :					
Work Phone:					
Describe how the employee was injured?					
Did the employee lose time from work?	☐ Yes	☐ No	☐ Unknown	If "yes", first day of lost time:	
Was there equipment involved?	☐ Yes	☐ No	If "yes", what was the equipment?		
What action will be taken to prevent recurrence?					
Other comments:					
Date:	Signature:		Title:		

After completing supervisor section, please forward form to district office

DISTRICT OFFICE COMPLETES THIS SECTION:		
Date form received in Business Office:		
Date reported to Insurance Company:		
Claim #:		
Claim Contact Person:		
Claim Contact Phone #:	Claim Contact Fax #:	
Comments/Notes:		
Date:	Signature:	Title: