Employee Accident/Injury Report Form Part 1

Form 513 - 7

Part A Employer Information

	Name of School
Good Spirit School Division No.204	

Employee Information

Employee name	
Home phone number	Work phone number
Occupation at time of Injury	

Part B Accident/Injury Information

Type of Claim ☐ First aid Only ☐ Medical Aid ☐ Lost Time			
Date of accident/injury (mm/dd/yy)	Time (a.m./p.m.)	Date Reported (mm/dd/yy)	Time (a.m./p.m.)
To whom was the accident/injury reported?	Position	Medical care required	
		☐ Yes ☐ No ☐ Don't know	
If health care provided, by whom? Doctor's name:		Identify the Employee's type of employment:	
		☐ Full Time ☐ Part Time ☐ Casual ☐ Student ☐ Other	

Were there any witnesses to the accident/injury:	Please provide the witness(es) name(s):
☐ Yes ☐ No	
Work time lost:	If yes, date of 1st full day lost:
☐ Yes ☐ No	If yes, expected date of return:

What happened? (include make, model, size, weight, etc. of equipment involved)	
Area of Injury	Signature:
☐ RT ☐ LT	Date:

Nature of injury				
☐ Bruise	☐ Strain/Sprain	☐ Concussion	☐ Allergic Reaction	☐ Other
☐ Burn	☐ Laceration/Abrasion	☐ Foreign Body	☐ Bite/Sting	