BARBOUR COUNTY BOARD OF EDUCATION

Employee Accident/Injury Report Form

NOTIFY WITHIN 24 HOURS

Name of Injured _____ SS# _____

Employee Address/Phone Number_____

_____

Date of Birth_____

Name of school or facility where injury occurred _____

Employment Category of person injured: ☐ Full time ☐ Part-time ☐ Contracted ☐ Substitute

Date of accident/injury_____ Time of accident/injury_____

Description of accident/injury (DETAILED PLEASE)

_____

_____

Witnesses _____

Did injured person require first aid? ☐ Yes ☐ No

Describe care/emergency action taken_____

_____

_____

Did injured require medical care from physician or transport to ER? ☐ Yes ☐ No

New Workers' Compensation regulations require notification of injury within **24 hours** of the occurrence. Complete this form and deliver to Barbour BOE Eddie Flowers, FAX # 304-457-3559 or e-mail to eflowers@access.k12.wv.us

_____ _____

Signature of Person Completing Form Date

_____ _____

Signature of Supervisor Date