

MINSTER LOCAL SCHOOLS  
EMPLOYEE INCIDENT REPORT

EMPLOYEE NAME  DATE OF BIRTH

DATE OF INCIDENT  TIME OF INCIDENT

LOCATION/CLASSROOM  ADDRESS

CITY/STATE/ZIP

DESCRIPTION OF INCIDENT

DESCRIPTION OF BODILY INJURY

WITNESSES

FIRST AID ADMINISTERED?  YES BY WHOM?   
 NO

SOUGHT PROFESSIONAL MEDICAL ATTENTION  YES WHERE?   
 NO

SIGNATURE OF EMPLOYEE

DATE

SIGNATURE OF WITNESS (if applicable)

DATE

SIGNATURE OF SUPERVISOR

DATE

CENTRAL OFFICE USE ONLY	
<input type="checkbox"/>	Placed on Restrict Duty
<input type="checkbox"/>	Placed on Job Transfer
<input type="checkbox"/>	Days Away from Work
<input type="checkbox"/>	Reported to Sheakley