**Rensselaer City School District**
**Employee Accident Report**
***(Return to Business Office within 24 hours)***

Employee Name _____ Phone Number _____

Home Address _____

Date of Hire _____ Job Title _____

---

Date of Injury _____ Time of Injury _____

Type of Injury_____ Part of Body _____

Date Employer Notified _____ Location of Accident _____

Describe How and Why Accident Occurred (in detail) _____

_____

_____

_____

_____

Name of Witnesses _____

**Employee Signature _____ Date _____**

**Supervisor Signature _____ Date _____**

---

Was Medical Treatment Provided by School Nurse?: Yes ____ No ___ If Yes, please have nurse describe:

_____

_____

_____

Initial Treatment (please check one):

- No Medical Treatment
- Minor On-Site Treatment by Employer
- Minor Clinic/Hospital Treatment
- Emergency Evaluation
- Hospitalization Greater than 24 Hours
- Future Major Medical/Lost Time Anticipated

**Nurse's Signature _____ Date _____**

Our Worker's Compensation Third Party Administrator is:
PMA Claims Service Center
PO Box 5231
Janesville, WI 53547-5231
1-888-476-2669
claimsmail@pmagroup.com