



**Tri-County Special Education Joint Agreement  
Jackson, Perry & Union Counties**

1725 Shomaker Drive Murphysboro, Illinois 62966  
Phone: 618-684-2109 FAX: 618-687-1638 C.W. (Chuck) Hamilton, Director

**ACCIDENT/INCIDENT REPORT  
TRI-COUNTY EMPLOYEES**

Page 1

**PART I** To be completed by injured employee at the time of incident or injury. The injured person is responsible for promptly notifying the Tri-County School Nurse (Martha Peebles) or Assistant Nurse (Barbara Zimmerman) of this accident/incident and of any recommendations of physicians.

Date of injury or incident \_\_\_\_\_ Time \_\_\_\_\_ Scheduled Work Hrs. \_\_\_\_\_

Name of injured person \_\_\_\_\_ Home phone \_\_\_\_\_

Address \_\_\_\_\_ Cell phone \_\_\_\_\_

Area of Normal Work Assignment \_\_\_\_\_ School \_\_\_\_\_

Site & Address at which accident/incident occurred \_\_\_\_\_

Reason injured person was at that site, if other than assigned area \_\_\_\_\_

Activity at time of accident/incident \_\_\_\_\_

Detailed description of injury (including part of body injured) \_\_\_\_\_

Witnesses \_\_\_\_\_, \_\_\_\_\_ Witness Phone # \_\_\_\_\_

Detailed description of immediate care given to injured person \_\_\_\_\_

INJURED EMPLOYEE'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

SUPERVISORS'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**PART II** To be completed by Tri-County School Nurse. This report will be Monitored and updated as necessary.

Date and time School Nurse was informed of injury/incident Date \_\_\_\_\_ Time \_\_\_\_\_

Nature of injury as described by employee \_\_\_\_\_

School Nurse's recommendations \_\_\_\_\_

Was additional medical treatment recommended? Yes \_\_\_\_\_ No \_\_\_\_\_ explain \_\_\_\_\_

Did employee seek additional medical treatment? Yes \_\_\_\_\_ No \_\_\_\_\_

If no, explain \_\_\_\_\_

If yes, Name of Medical Provider \_\_\_\_\_ Date of care \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Recommendations of Medical Provider \_\_\_\_\_

Diagnosis \_\_\_\_\_ Follow-up Visit? \_\_\_\_\_ Referral to Specialist? \_\_\_\_\_

Name & Address of Specialty Physician \_\_\_\_\_ Phone \_\_\_\_\_

Signature of Nurse \_\_\_\_\_ Date \_\_\_\_\_

(PLEASE COMPLETE PAGE 2)

