Accident Report

To be filled out at the time of the accident by the injured person or the person caring for an injured person:

Date ______________________________

Name (Last, First, Middle)

____

Address

____

Phone _________________________ Age ________ Sex ________

School ____

Department or Location where accident or illness/exposure occurred:

____

How did it happen/could it have been prevented?

____

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Signature: ____

FAX IMMEDIATELY with Worker's Compensation First Report of Injury or Illness to:

Valerie Galan
Risk Mgmt/Employee Bnfts Coord
Comal ISD Central Office
(830) 221-2152 Fax
(830) 221-2102 Phone