Accident Report Form

Copper Point Mutual Insurance Co. Policy #1002227

Employee Full Name: .....
Employee SS#: .....
Employee Birthdate: .....
Employee Phone Number: .....
Employee Address: .....
Job Title: .....
Start & End Time of Work Day: .....

District: .....
School Site: .....
Address of Accident/Injury: .....
Date of Accident/Injury: .....
Time of Accident/Injury: .....
Part of Body Injured: .....
Nature of Accident/Injury: .....

Will you seek medical attention for this accident/injury? ☐ Yes ☐ No

If yes, where? .....

(If medical treatment was necessary, please send all documentation immediately.)

Where did the accident/injury take place? .....

Describe how the accident/injury occurred: .....

(Please indicate what job was being performed and what went wrong. Include any machine, tool, or object that was being used in connection with the accident.)

Please indicate how this type of accident can be prevented in the future (if at all): .....

Name(s) of Witness(es): .....

Copperpoint Mutual Insurance Company
3030 N. 3rd Street
Phoenix, AZ 85012

Please send completed form to workerscomp@esiaz.us
Phone: 480-840-7453