

EMPLOYEE'S FIRST REPORT OF INJURY

EMPLOYEE NAME: _____
ADDRESS: _____
SOCIAL SECURITY NUMBER: _____
DATE OF BIRTH: _____
DISTRICT JOB TITLE: _____
DATE AND TIME OF INJURY: _____
LOCATION OF INJURY: _____

Did the Employee *immediately* notify his/her supervisor of injury/illness? Yes No
If not, please explain: _____

What was the Employee doing when the accident occurred?

How did the accident/injury occur?

What was the injury or illness? *(List the part of the body affected, and explain how it was affected.)*

What object or substance, if any, directly harmed the Employee?

Name and address of physician/healthcare professional that treated Employee:

If treatment was given away from the worksite, please list the name and address of the place it was given.

Was the Employee treated in an emergency room? Yes No
Was the Employee hospitalized overnight as an in-patient? Yes No
Did the Employee lose any workdays due to injury/illness? Yes No
If yes, please indicate how many days? _____ Days

Employee Signature / Date

District Administrator Signature / Date