FIRST REPORT OF INJURY

Date of Report: __/__/__

Date Notified Employer: __/__/__

Date of Injury: __/__/__ Time of Injury: __ : __ AM/PM (circle one)

EDUStaff Employee Information:

Employee Name (First, Last, M.I.): _____

SSN: ___-___-_____ DOB: __/__/__ Sex: M/F (circle one)

Address (Number & Street): _____

City: _____ State: _____ Zip: _____

Phone Number: ___-___-___ Hire Date: __/__/__ Job Title:_____

Injury Report Information:

Job Location: _____

Start Time: __ : __ AM/PM (circle one) End Time: __ : __ AM/PM (circle one)

Address (Number & Street): _____

City: _____ State: _____ Zip: _____

Witness to Injury: _____Witness Phone Number(s): ___-___-___

Explain How Injury Occurred: _____

_____

_____

Nature of Injury: _____

Part of the body directly affected by the injury: _____

Last Day Worked: __/__/__ Date Employee Returned: __/__/__

Was the injury fatal? Yes/No (circle one) If yes, date of fatality: __/__/__

Did employee seek medical treatment? Yes/No (circle one)

If yes, date of treatment: __/__/__

Name of treatment facility: _____

Address (Number & Street): _____

City: _____ State: _____ Zip: _____

Restrictions: _____

_____

Expected return to work date: __/__/__

District Information:

Building Supervisor: _____ Phone Number: ____-____-____

_____ _____

Supervisor Signature Date:

Feedback:_____

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