

INDEPENDENT SCHOOL DISTRICT 196
Rosemount-Apple Valley-Eagan Public Schools
Educating our students to reach their full potential

Series Number 406.7.1P Adopted July 1980 Revised August 2013

Title Supervisor's Report of Employee Injury

This form is to be completed for each occurrence of employee injury or work related illness and submitted to the Payroll Department via fax # 651-423-7788 within 24 hours of the incident.

Employee name _____ Employee number _____

Job Title _____ School/Building _____

Date of incident _____ Time employee started work _____ Time of incident _____

What date did employee first report injury/illness? _____ Reported to _____

Part(s) of Body Involved (please circle R for right or L for left as appropriate)

- | | | | | | | |
|---|--------------------------------------|---------------------------------------|--|------------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> abdomen/groin | <input type="checkbox"/> ankle (R/L) | <input type="checkbox"/> arm (R/L) | <input type="checkbox"/> back | <input type="checkbox"/> chest/rib | <input type="checkbox"/> ear (R/L) | <input type="checkbox"/> elbow (R/L) |
| <input type="checkbox"/> eye (R/L) | <input type="checkbox"/> face | <input type="checkbox"/> finger/thumb | <input type="checkbox"/> foot/toes (R/L) | <input type="checkbox"/> forehead | <input type="checkbox"/> hand (R/L) | <input type="checkbox"/> head |
| <input type="checkbox"/> hip (R/L) | <input type="checkbox"/> knee (R/L) | <input type="checkbox"/> leg (R/L) | <input type="checkbox"/> mouth | <input type="checkbox"/> neck | <input type="checkbox"/> nose | <input type="checkbox"/> side (R/L) |
| <input type="checkbox"/> shoulder (R/L) | <input type="checkbox"/> wrist (R/L) | <input type="checkbox"/> other _____ | | | | |

Nature of Injury/Illness

- | | | | | | |
|---|--------------------------------------|---|--|--|-------------------------------------|
| <input type="checkbox"/> abrasion/scratch (skin not broken) | <input type="checkbox"/> bruise | <input type="checkbox"/> burn | <input type="checkbox"/> choking | <input type="checkbox"/> concussion | <input type="checkbox"/> dermatitis |
| <input type="checkbox"/> dislocation | <input type="checkbox"/> fracture | <input type="checkbox"/> hearing | <input type="checkbox"/> infection | <input type="checkbox"/> laceration/cut | <input type="checkbox"/> poisoning |
| <input type="checkbox"/> repetitive/cumulative | <input type="checkbox"/> respiratory | <input type="checkbox"/> skin punctured | <input type="checkbox"/> sprain/strain | <input type="checkbox"/> vision impaired | |
| <input type="checkbox"/> other _____ | | | | | |

Where and How Injury/Incident Occurred

Did injury/incident occur on District 196 property? yes no

If yes: What school/building? _____ Where on property? _____

If no: Name and address of location: _____

How did the injury/incident occur and what was employee doing before incident (give details)? _____

Describe the injury/incident in detail: _____

What, if any, tools, equipment, objects or substances were involved? _____

Action Taken and Follow Up

What, if any, first aid treatment was given? _____

Employee: returned to work within ___ minutes or ___ hours left work at _____ and returned _____
(time & date) (time & date)

Did employee go or plan to go to a medical provider? yes no If yes, complete the following:

Name of clinic/hospital: _____

Name of medical provider: _____

Address: _____

Phone: _____

Ambulance transport? yes no

Emergency room visit? yes no

Overnight stay in hospital? yes no

Witness name and job title

Witness phone #

Supervisor or school nurse completing report

Date

Principal/administrator signature

Date signed