

*EMPLOYEE
INJURY REPORT*

SCHOOL _____

DATE OF INJURY _____

NAME _____

ADDRESS _____

CITY _____

ZIP _____

BIRTHDATE _____

DATE OF HIRE _____

SOCIAL SECURITY NUMBER _____

(only needed if medical treatment is needed by clinic or hospital)

INJURY _____

OCCURRED HOW _____

WHERE _____

CARE GIVEN _____

SENT TO CLINIC YES NO (circle one)

WITNESSES _____

REPORTED BY _____

ADMINISTRATOR SIGNATURE _____

Keep one copy for your file and send one copy to Business Office.