St. Joseph School District

1415 N 26th St., St. Joseph, MO 64506

(816-671-4002 (Human Resources)

Workers Compensation 1st Report of Injury Form

CLAIM TYPE: (NO Medical) -report injury____ medical ____ lost time_____
(check one of the above)

EMPLOYEE INFORMATION Injury Date:_____

PLEASE PRINT

Name: _____ SSN:_____

Home Phone:_____Cell #:_____Other:_____

Date of birth:_____ Gender: Male ____Female _____ (check one)

Address:_____ City, State, Zip: _____

Marital Status: Married _____ Single_____ Divorced _____ Widowed ____ (check one)

Hire Date _____ Full time _____ Part time _____ (check one)

Days worked per week _____ Hours:_____ Position: _____

Work address:_____ Building: _____

Health Insurance: ____ SJSD ____Other:_____

ACCIDENT INFORMATION

Time of accident:_____ (AM OR PM) --please circle one Time work began:_____

Date employer was notified: _____ Was injury on employer's premises? _____

If not, please give address (Street, City, State, Zip)_____

Last work date:_____ Is this injury a questionable case? Yes ____ No ____

Describe injury:_____

_____

_____

(OVER)

Revised April 2025

Was the injured taken by ambulance? Yes ___ No ____

Was this injury student involved? Yes ___ No ____

If applicable, please advise the grade level of the student involved and if the student has an IEP or 504 plan.

Grade Level _____ IEP _____ 504plan _____

Body part injured (indicate left, right, etc.):_____

What was the direct cause of the injury? (machine, tool, object, substance, etc.):_____

_____

How could this injury have been prevented? _____

_____

CONCENTRA
5506 Corporate Dr.
Suite 1700
St. Joseph MO 64507
(816) 671-4880
Please call Human Resources, 671-4002 before seeking medical attention.

Were safeguards provided? Yes ___ No ___

Was proper safety equipment used? Yes ___ No ___

Explain: _____

Were drugs or alcohol involved? Yes ___ No ___

WITNESS: Name: _____ Address:_____ Phone:_____

Administrator's signature_____

Injured Employee's signature_____