PIEDMONT PUBLIC SCHOOLS

Occupational Injury or Illness Report

This form contains sections to be completed by both the supervisor and the employee. The accident should be investigated by the supervisor of the injured employee or department involved. It should be completed as soon as possible to obtain the most accurate information .

SUPERVISOR SECTION

Date of Injury:	Date Reported:	Employer Name: **Piedmont Public Schools**		
Name of Employee:		Employee #:		Date of Birth:
Home Address:		City:	State:	Zip Code:
Home Phone:	Cell Phone:	Work Phone:		Extension:
Sex:	Occupational Title:	Date of Employment		
Time Work Shift Began: AM / PM	Time Accident Occurred: AM / PM	Day of the Week: M T W TH F S SU		
Location of the Accident:				

INJURY TYPE

	25	Foreign Body in Eye		81	Animal, Insect, Human Bite		28	Fracture
	43	Cut/Puncture		46	Hernia/Rupture		02	Amputation
	40	Abrasion/Scratches		99	Heart Attack/Stroke		68	Skin Irritation/ Dermatitis
	10	Bruise/Contusion/Crushing		72	Hearing Impairment		07	Concussion/Loss of Consciousness
	49	Sprain/ Strain		66	Exposure (Chem. Temp. Elect)		24	Death
	04	Burn (Chem, liquid, Electrical)		81	Exposure (Blood/ Body Fluid)		00	Other:

INJURY CAUSE

	46	Struck by/ Against Object		31	Noise		85	Animal, Insect, Human
	25	Fall-Same Level, Different Level		98	Repetitive Motion/Trauma		84	Hot Object, Substance or Fire
	54	Jumping or Climbing		30	Slipping/Tripping		26	Caught in /Under/ Between
	48	Vehicle Accident/ Struck by Vehicle		57	Pushing/Pulling/ Lifting/ Carrying		59	Other:

Was injury caused by another person, faulty/broken equipment, a vehicle?
YES
NO

If yes, explain:

BODY PART INJURED

	02	Head/Neck/Face/Mouth		44	Wrist (Left Right)		74	Hips/Buttocks
	05	Eye (Left Right)		45	Hand (Left Right)		46	Fingers (Left Right) Digit:
	04	Ear (Left Right)		61	Back (Upper Lower)		83	Knee (Left Right)
	48	Shoulder (Left Right)		67	Chest/Abdomen (Including Internal Organs)		85	Ankle (Left Right)
	41	Arm (Left Right)		66	Pelvis/Groin		86	Foot (Left Right)
	42	Elbow (Left Right)		83	Leg (Left Right) (Thigh Calf)		87	Toes (Left Right) Digit:
	73	Respiratory		01	Other:		96	No Physical Injury

FIRST AID OR MEDICAL TREATMENT

Was first aid given? YES NO	If yes, by whom:
Was medical treatment required by a physician or hospital? YES NO	Physician/ Hospital Name, Address, and telephone number:

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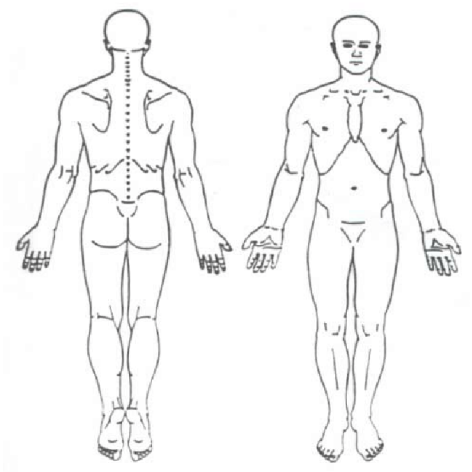
EMPLOYEE'S STATEMENT	
Name of Employee:	Date you first noticed the pain:
Did the pain develop gradually or suddenly? (Circle one) Gradually Suddenly	
If the pain developed suddenly, exactly what were you doing when the pain was felt?	
If nothing unusual or unexpected happened, what do you think caused the pain?	
List body parts injured:	
Have you discussed this pain with anyone at work? (Circle one) YES NO	
If yes, with whom and when?	
Have you had any recent non-work related injuries or illnesses? (Circle one) YES NO	
If yes, what was the problem, when did it occur, and what (if any) medical treatment did you receive?	

Show part(s) of body injured, noting the longevity, type and degree of pain

On the diagram below, indicate the location, description and level of pain you are experiencing at this time. Example: "A-6= Ache-Severe pain"



Note type of pain:		
A=Ache	B=Burning	P=Pins and Needles
N=Numbness	S=Stabbing	O=Other
Note level of pain:		
0	No Pain	
1	Mild pain, you are aware of it, but it doesn't bother you	
2	Moderate pain that requires medication to tolerate the pain	
3	More severe pain	
4	Severe pain	
5	Intensely severe pain	
6	Most severe pain, unbearable	
Was medical treatment away from the job site offered? (Circle one) YES NO		
If treatment was offered, but declined, employee must sign here:		

Have you ever received medical treatment for the injured body part(s) listed above? (Circle one) YES NO	
If yes, please note the date and physician/hospital where treatment was rendered.	
Are you currently receiving social security **DISABILITY** payments (***not Social Security retirement payments***)? (circle one) YES NO	
Are you currently receiving Medicare assistance? (Circle one) YES NO	

"I declare under penalty of perjury that I have examined all statements contained herein, and, to the best of my knowledge and belief, they are correct and complete."

EMPLOYEE NAME (PRINTED) _____ SIGNATURE _____ DATE _____

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SUPERVISOR'S STATEMENT
Name of Employee:
As a result of your investigation, what do you believe occurred and why?
From your investigation, is the validity of the accident in doubt? (Circle one) YES NO
If yes, explain why.
Was a third party at fault? (Circle one) YES NO
If yes, explain.
Were there any witnesses? (Circle one) YES NO
If yes, list the witnesses below.

Name of Witness:	Phone:	Address:	Date:

SUPERVISOR NAME (PRINTED) _____ SIGNATURE _____ DATE _____