Updated – March, 2022

Jefferson Parish Schools
FIRST REPORT OF INJURY

Date of Request:		Date of Injury & Time:	
If Fatal, Date of Death:		Date Employer Knew of Injury:	
Normal Start Time:	Date Employee back to work:	At Same Wage: (Y / N) Date Last Full Day Paid:	Date Disability Began:
First Name/MI:		Last Name/Suffix:	
Employee Address: (Include Parish & Zip)			
Social Security #:		Employee ID#:	
Sex (Female/Male):		Birth Date:	

Race: ***Circle Choice:***	American Indian / Alaskan Native		Marital Status: ***Circle Choice:***	Married
	Asian			Single
	Black			Divorced
	Hispanic			Separated
	White	OTHER		Widowed

# of Children Under 18:		Occupation:	
School / Department:		Date of Hire:	
Place of Injury:	Employer's Premises: (Y / N)	If no, exact location (Address):	
What was the injured doing when injured? (Be specific. If using tools or equipment or handling material – name them and tell what he was doing with them) List names of witnesses (if applicable).			
Did Injury or Disease occur because of:	Mechanical Defect (Y/N):	Unsafe Act (Y / N): If Yes, Describe -	Amputation (Y/N):
Nature & Location of Injury or Disease (Describe fully including parts of body affected):		If OCC Disease Date of Initial Diagnosis:	
Attending Physician & Address (If Hospital Involved – Indicate):			

Principal/Supervisor Signature: _____ Date: _____

-----FOR OFFICE USE ONLY----

Employee ID#:	LOC:	CLASS:	INJ:
Weekly Salary $:			