



Union Public Schools
Employee Injury and Incident Report

CONFIDENTIAL COMMUNICATION

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Date Sent:	Number of Pages including cover:
To: Christine Mason Mgr. of Hiring, Data & Claims Specialist Phone: (918) 357-6053	From: Phone: Fax:

**This cover sheet must be used to fax all Employee
Injury/Incident Reports to Human Resources**

Prior to submitting the Injury/Incident Report Human Resources, the supervisor should verify which of the following items have been completed by initialing next to the following:

- _____ Employee Reviewed and Verified Accuracy*
- _____ Signed by Employee*
- _____ Supervisor Reviewed for Accuracy
- _____ Signed by Supervisor
- _____ Completed and faxed within 48 hours of employee's return to work
- _____ Copy retained for Supervisor's File

Union Public Schools
Employee Injury and Incident Report

Complete this form for all on-the-job injuries and incidents. The employee should complete the "Employee's Statement" in his/her own handwriting in the presence of their supervisor. The supervisor must sign and submit this form to the Human Resources Department with the fax cover sheet within 24 hours of the incident. If employee is unavailable to assist in completion of this form, supervisor must complete and forward this form within 24 hours and a Supplemental Injury/Incident Report must be completed within 48 hours of employee's return to work.

Supervisor Section						Page 1 of 2	
Date of Injury:		Date Reported:		Employer Name:			
Name of Employee:			S.S. No:				
Home Address:							
Home Phone:		Work Ext:		Date of Birth:			
Cell Phone:							
Sex:		Occupational Title:			Date of Employment:		
Time Work Shift Began:			Time Accident Occurred:			Day of week	
AM/PM			AM/PM			M T W TH F S SU	
Location:							
Injury Type (Circle)							
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 (Circle)							
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 (Circle)							
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)	82	Leg (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:							
MedWise Urgent Care 1095 N Aspen Ave, Broken Arrow, OK 74012							

Explanation of injury (How, When, Where)

Date you first noticed the pain?

Did this pain develop gradually?

Or 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? If yes, with whom and when? Yes No

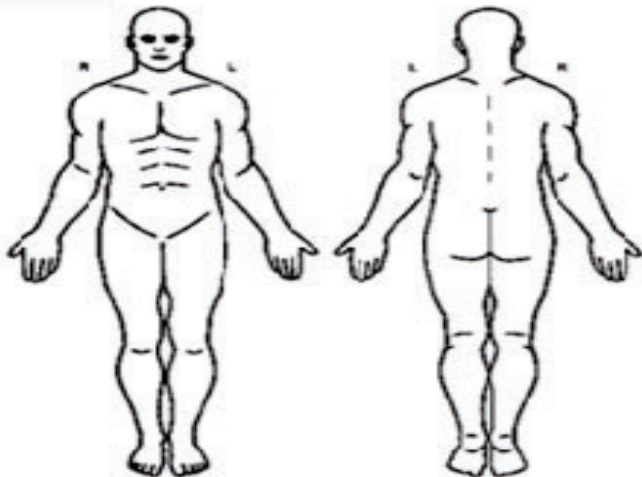
Have you had any recent non-work related injuries/illnesses? If yes, please list: Yes No

If the above answer is yes, what was the problem, when did it occur, and what (if any) medical treatment did you receive?

Show part(s) of the 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 & 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?

Yes

No

If treatment was offered, but declined, please sign:

Have you ever received medical treatment for the injured body part(s) listed above? If so, please note the date and physician/hospital where treatment was rendered.

Yes

No

Are you currently receiving Social Security **Disability** Payments (*not Social Security retirement payments*)?

Yes

No

Are you currently receiving Medicare assistance?

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: (Print)****Employee Signature:**

Date:

Supervisor's Statement

As a result of your investigation, what do you believe occurred and why?

From your investigation is the validity of the accident in doubt?

Yes

No

If yes, explain why.

Was a third party at fault? If yes, explain

Were there any witnesses? If yes, please list

Name**Address****Phone****Date****Supervisor's Signature:****Date:**