Employee Report of Industrial Injury or Incident

Today's Date: _____
Injured EE's Name: _____ Sex: M / F
Injured EE Address_____
City: _____ State: _____ Zip Code: _____
Injured Employee's Tel. #: _____ Cell #: _____

Date of Injury/Incident: _____ Time Incident Occurred: _____AM/PM
Location Where Injury Occurred: _____ On School District's Premises: Yes / No
Date Reported Injury? _____ Injury Reported to Whom? _____
What Caused the Incident or Injury? _____
Body Part(s) Involved: _____
Describe How the Injury Occurred (Who/What/When/Where & Why? Please include task being performed and tools/ or object(s) involved if they contributed to the injury) and witnesses to the incident:

_____
_____
_____
_____

If injury caused by a tool or other district property, has the item been put aside? **Yes / No** If Yes, where is the item located now? _____
Witness Names & Phone #'s: _____

To Be Completed By Supervisor

Wages (If known): $_____per week # Hours/Day Worked? _____ # Days Worked/Week? _____
Total Hours Worked Per Week: _____ Time Employee Normally Begins Work: _____
Was Employee Unable to Work On Any Day Following Injury? Yes / No Last Day Worked? _____
Has Injured Worker Returned to Work Yet? Yes / No If Yes, What Date Returned? _____
Corrective Action Required? _____
Has Injured Worker been referred, or is Injured Worker planning on seeking medical treatment/care? Yes/No
Name of Frontline Medical Provider? _____
Frontline Medical Provider's Telephone Number (if known): _____
What has been or will be don't to prevent future similar injuries? _____
_____
Does the employee have any input on how this type of injury can be avoided in the future? _____
_____
Any in-service/training necessary for staff: Yes□ No □ If so, when will this be done? _____
Any physical deficiencies need correcting? Yes □ No □ If so, what steps have been taken: _____
_____
Are any procedural/operational changes necessary? _____

TYPE OF INCIDENT (Please Circle One):
A. INJURY **B. ILLNESS** **C. INCIDENT ONLY/NO MEDICAL CARE REQUIRED**
Additional Comments: _____
_____
_____

If more first aid given, be sure to fill out Form 5020 – Employers Report of Occupational Injury or Illness.

Supervisor's Name: _____ Date: _____