

First Report of Injury (for staff injuries occurring during working hours)

TO BE COMPLETED BY EMPLOYEE AND/OR SUPERVISOR UNLESS OTHERWISE STATED.

DEPT: Custodial / Food Services / School (Circle one)

LOSS DATE: _____ (When did it happen?)

LOSS TIME: _____ (What time did it happen?)

EMPLOYER REPORT DATE: _____ (Completed by Bus Off)

KNOWLEDGE DATE: _____ (When reported to supervisor?)

DESCRIPTION: (What were you doing? What happened? Why?)

CAUSE: _____ (Choose from list on page 2)

NATURE: _____ (Choose from list on page 2)

BODY PART: _____ (Choose from list on page 2)

JOB TITLE: _____ (Choose from list on page 2)

EMPLOYEE NAME: _____

HOME ADDRESS: _____

HOME CITY: _____

HOME STATE: _____ ZIP: _____

HOME/MOBILE NUMBER: _____

WORK NUMBER: _____

EMAIL: _____

DATE OF BIRTH: _____ DATE OF HIRE: _____

GENDER: _____ MARITAL STATUS: _____

SOCIAL SECURITY #: _____ (Completed by Business Office)

INJURED ON PREMISE: YES ☐ NO ☐

LOCATION OCCURRED: _____ (School/Location)

FULL WAGES ON INJURY DAY: YES ☐ NO ☐ (Completed by Bus Off)

AVE.WEEKLY WAGE: _____ (Completed by Business Office)

LOST TIME FROM WORK? YES ☐ NO ☐ (Completed by Bus Off)

FIRST DAY WITH LOST TIME: _____ (Completed by Business Office)

RETURN TO WORK DATE: _____ (Completed by Business Office)

NUMBER OF DEPENDENTS: _____

TIME BEGAN WORK: _____

SUPERVISOR NAME: _____

SUPERVISOR PHONE NUMBER: _____

TREATMENT SOUGHT:

NONE ☐

ON-SITE ☐

MINOR CLINIC/HOSPITAL TREATMENT ☐

EMERGENCY MEDICAL PROCEDURES ☐

HOSPITALIZATION 24HRS+ ☐

MAJOR MEDICAL/LOST TIME ANTICIPATED ☐

WAS THE EMPLOYEE HOSPITALIZED? YES ☐ NO ☐

PHYSICIAN/HEALTHCARE PROF. SEEN: _____

MEDICAL FACILITY NAME: _____

ADDRESS: _____

CITY: _____

HOME STATE: _____ ZIP: _____

DID EMPLOYEE RETURN TO WORK? YES ☐ NO ☐

INJURY REPORTED TO: _____

WITNESS: _____

TO BE COMPLETED BY SUPERVISOR

CAUSE OF INJURY: _____

WAS EMPLOYEE WEARING SAFETY GEAR? YES ☐ NO ☐

IF NO, EXPLAIN: _____

ACTION TAKEN TO PREVENT SIMILAR ACCIDENTS: _____

REMARKS _____

INVESTIGATED _____ BY: _____

Signed _____ Date _____

REVIEWED BY: (Completed by Business Office)

Signed _____ Date _____

CAUSE	NATURE	BODY PART	JOB TITLE
STRUCK AGAINST	INSECT BITE	ABDOMEN	SCH/BUS/DRIVER
STRUCK BY	AMPUTATION	ANKLE	SCH/CAFETERIA
FALL DIFF LEVEL	ASPHYXIATION	ARM	SCH/CUSTODIAN
FALL SAME LEV.	ANIMAL BITE	BACK	SCH/NURSE
CAUGHT BETWEEN	BURN/SCALD	BOD PTS, NEC	SCHOOL TEACHER
HOLDING PNT UP	CARPAL TUNNEL	BODY SYSTEM	SCHOOL/AIDE
LIFTING	BURN(CHEMICAL)	BRAIN	SCHOOL/CLERICAL
LIFT OBJ LOWER	CONCUSSION	BUTTOCKS	SCHOOL/CROSSING
CARRYING	INFECT. DISEASE	CHEST/RIBS	
BENDING/REACH	CONTUSION	DIGEST SYS	
WHEELCHAIR	CUT/PUNCTURE	EAR	
FALL ON STAIRS	SPLINTER	ELBOW	
FALL OUTSIDE PR	DERMATITIS	EXCRET SYS	
STRUCK BY DOOR	POISON IVY	EYES	
HANDTOOLS	DISLOCATION	FINGER	
POWER HAND TOOL	ELECTRIC SHOCK	FOOT	
RUB/ABRADE	FRACTURE	GROIN	
SPLASHING LIQ	FROSTBITE	HAND	
FOREIGN BDY EYE	HEARING LOSS	HEAD	
STEP ON OBJ.	VISION LOSS	HEART	
CUTS/NOT NEEDLE	HEAT EXHAUSTION	HEEL	
PUNCH NDLE DISC	HERNIA	HIP	
PUNCH NDLE USE	HUMAN BITES	JAW	
COLL /PERSON	HUMAN SCRATCHES	KNEE	
STRUCK BY PNT	INFLAM MUSCLES	LEG	
OCCUP DISEASE	POISONING	LO EXTR	
EXPL & FIRE	PNEUMOCONIOS	LO EXTR MULT	
COMM.DISEASE	SUNBURN	LO EXTR,NEC	
BODY REACTION	SPRAIN	LOWER LEG	
ANIMAL BITE	STRAINS	MOUTH	
OVEREXER/STRESS	ULCERATIONS	MULTIPLE PTS	
ELECTRIC SHOCK	VARICOSITIES	MUS/SKEL SYS	
TEMP. EXTREME	HEMORRHOIDS	NECK	
CONTACT TOXIC	MULT.INJURIES	NERV SYS/STRESS	
ASSAULT	FOREIGN BODY	NOSE	
INSECT BITE	MENTAL DISORDER	OTH BOD SYS	
MOTOR VEH ACC.	NERV SYS/STRESS	PELVIS	
TRIPPED/TURNED	RESP. SYSTEM	RESP SYS	
CLIMBING	EYE IRRITATION	SCALP	
PULLING HOSE	PROTH DEVICE	SHOULDER	
CONTAGIOU PLANT	OCC. DISEASE	SKIN	
SHOT	HEART ATTACK	TEETH	
HLD-UP RIOT	HYPERTEN/STROKE	THIGH	
ROBBERY	FAINTING	TOES	
HORSEPLAY/FIGHT	SCARRING	TRUNK	
WINDBLOWN OBJ.	cardio/vascular	TRUNK MULTI	
REPETITIVE MOT.	NOT CLASSIFIED	UP EXTR	