

FIRST REPORT OF INJURY OR DISEASE

Return a copy of the completed form to Tara Walters in the Health Services Office, which is located in the high school.

Name of building principal you have notified regarding this injury: _____

Employee Name (First, Middle, Last)		Social Security Number		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Employee Home Phone #	
Employee Street Address		City		State	Zip Code	Occupation	
Birthdate		Date of Hire		County and State where accident or exposure occurred			
		Start Time <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.		Hours Per Day	Hours Per Week	Days Per Week	
Employee's Usual Work Schedule When Injured							
Employer's Usual Full-Time Schedule For This Type of Work at Time of Employee's Injury							
Injury Date	Time of Injury <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	Last Day Worked	Date Employer Notified		<input type="checkbox"/> Date Returned to work <input type="checkbox"/> Estimated Date of Return		
Were you treated in an emergency room? <input type="checkbox"/> yes <input type="checkbox"/> No							
Were you hospitalized overnight as an in-patient? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Name and Address of Treating Practitioner and Hospital:							
Injury Description-							
What happened to cause the injury or illness? (Describe how the injury occurred).							
What was the injury or illness? (State the part of body affected and how it was affected)							
Any Witnesses? If yes, please list name/s below.							