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 ☐ M ☐ 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	Hours Per Day	Hours Per Week	Days Per Week
Employee's Usual Work Schedule When Injured	☐ A.M. ☐ P.M.			
Employer's Usual Full-Time Schedule For This Type of Work at Time of Employee's Injury				

Injury Date	Time of Injury ☐ A.M. ☐ P.M.	Last Day Worked	Date Employer Notified	☐ Date Returned to work ☐ Estimated Date of Return

Were you treated in an emergency room? ☐ yes ☐ No

Were you hospitalized overnight as an in-patient? ☐ Yes ☐ No

Name and Address of Treating Practitioner and Hospital:

Injury Description-

What was the employee doing just before the incident occurred? (Describe activity)

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)

What object or substance directly harmed the employee?

Any Witnesses? If yes, please list First and Last name/s below.