

FIRST REPORT OF INJURY

Date of Report: ___/___/___
Date Notified Employer: ___/___/___
Date of Injury: ___/___/___ Time of Injury: ___ : ___ AM/PM (circle one)

EDUStaff Employee Information:

Employee Name (First, Last, M.I.): _____
SSN: ___-___-___ DOB: ___/___/___ Sex: M/F (circle one)
Address (Number & Street): _____
City: _____ State: _____ Zip: _____
Phone Number: ___-___-___ Hire Date: ___/___/___ Job Title: _____

Injury Report Information:

Job Location: _____
Start Time: ___ : ___ AM/PM (circle one) End Time: ___ : ___ AM/PM (circle one)
Address (Number & Street): _____
City: _____ State: _____ Zip: _____
Witness to Injury: _____ Witness Phone Number(s): ___-___-___
Explain How Injury Occurred: _____

Nature of Injury: _____
Part of the body directly affected by the injury: _____
Last Day Worked: ___/___/___ Date Employee Returned: ___/___/___
Was the injury fatal? Yes/No (circle one) If yes, date of fatality: ___/___/___

Did employee seek medical treatment? Yes/No (circle one)

If yes, date of treatment: __/__/__

Name of treatment facility: _____

Address (Number & Street): _____

City: _____ State: _____ Zip: _____

Restrictions: _____

Expected return to work date: __/__/__

District Information:

Building Supervisor: _____ Phone Number: ____-____-____

Supervisor Signature Date:

Feedback: _____

