

Supervisor's Report of Industrial Injury or Incident

TYPE OF INCIDENT (Please Check One)

Today's Date: _____

INJURY

ILLNESS

INCIDENT ONLY / NO MEDICAL CARE REQUIRED

Injured Employee's Name: _____ Sex: M F

Date of Injury/Incident: _____ Time Incident Occurred: _____ AM _____ PM

Location Where Injury Occurred: _____ On School District's Premises: Yes No

Date Employee Reported Injury? _____ Injury Reported to Whom? _____

If Limited Term or Sub Employee:

Wages: \$ _____ (per hour) # Hours/Day Worked? _____ # Days Worked/Week? _____

Total Hours Worked Per Week? _____ Time Employee Normally Begins Work? _____

Describe how the Injury Occurred (Who, What, When, Where, and Why)? Please include task being performed and tools or object(s) involved that contributed to the injury: _____

Body Part(s) Involved: (Please Specify Right or Left) _____

If injury caused by tool or other district property, has the item been put aside? Yes No

If yes, where is the item located now? _____

Witness: _____ Phone: _____

Describe Immediate Corrective Action _____

Date Immediate Corrective Action was Completed _____ By Whom _____

Additional Comments: _____

Supervisor's Name: _____ Date _____