Employee's Work Injury Report / Notice to Employer

NOTE: This report is for "Internal Information Only"

Name_____

Address_____ **Sex M F**

Telephone_____**(H)**_____**(C) Date of Birth**_____

Dept / Location_____ **Job Title**_____

Date of Injury_____ **Time of Injury**_____ **A.M. / P.M.**

Where did the injury occur?_____

What were you doing when the injury occurred?_____

Describe the injury or illness in detail and indicate the part of the body affected. (Designate Right or Left if appropriate)

_____

_____

Have you had a previous similar injury? If yes, please explain._____

_____

Name of witness(es) to your injury._____

Name and address of physician._____

Diagnosis/Care prescribed if known at this time._____

Did you or do you expect to lose time from work? YES NO How Long?_____

What day(s) did you miss work?_____ **Return Date?**_____

_____

Employee's Signature **Date**

_____

Supervisor's Signature **Date**

**** Please forward this form to Central Office once the Building Administrator has signed and dated it. If you seek medical attention, you will need to come to the Education Center immediately to fill out additional paperwork. ****