FIRST REPORT OF INJURY

Date of Report: _____

Date Notified Employer: _____

Date of Injury: _____ Time of Injury: _____

EDUStaff Employee Information:

Employee Name (First, Last, M.I.): _____

SSN: _____ DOB: _____ Sex: _____

Address (Number & Street): _____

City: _____State: _____ Zip: _____

Phone Number: _____ Hire Date: _____ Job Title: _____

Injury Report Information:

Job Location: _____ Start Time: _____ End Time: _____

Address (Number & Street): _____

City: _____State: _____ Zip: _____

Phone Number: _____

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? _____ If yes, date of fatality: _____

Did employee seek medical treatment? _____

If yes, date of treatment: _____

Name of treatment facility: _____

Address (Number & Street): _____

City: _____ State: _____ Zip: _____

Restrictions: _____

_____

Expected return to work date: _____

District/College Information:

Building or College Supervisor: _____

Phone Number: _____

Supervisor Signature: _____ Date: _____

Feedback: _____

_____

_____

_____

_____

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