



# INCIDENT/INJURY OR OCCUPATIONAL ILLNESS REPORT

NAME (LAST, FIRST, MI) \_\_\_\_\_ HOME ADDRESS \_\_\_\_\_ CITY/STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HM PH \_\_\_\_\_ WK PH \_\_\_\_\_ HIRE DATE \_\_\_\_\_ DOB \_\_\_\_\_ M F \_\_\_\_\_

SS# \_\_\_\_\_ JOB TITLE \_\_\_\_\_ DEPARTMENT \_\_\_\_\_

FT, Hourly, Sub, Temp, Volunteer SEA, SAEOP, 609, Maint/Trans, Other \_\_\_\_\_ School/Building Assigned \_\_\_\_\_  
Circle one circle Union represented

Date of Incident \_\_\_\_\_ Time \_\_\_\_\_ am/pm Did Incident occur off District premises? \_\_\_ If yes, where? \_\_\_\_\_

Specific location of Incident \_\_\_\_\_  
(building, classroom, lab, shop, stairs, playground, gym, cafeteria, etc)

Parts of the body affected (low back, right wrist, eye, etc): \_\_\_\_\_

What were you doing when the Incident occurred? \_\_\_\_\_

Object or substance that directly caused the Incident (machine that struck you, chemical, item lifted) \_\_\_\_\_

In your opinion, could anything be done to prevent similar incidents in the future? \_\_\_\_\_

Describe in detail how the Incident occurred (include tools, machinery, chemicals or fumes that may have been involved):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Witnesses to incident: Names and phone numbers \_\_\_\_\_

To whom did you report the incident? \_\_\_\_\_ When? \_\_\_\_\_ Explain any delays in reporting the incident or in seeking medical treatment \_\_\_\_\_

Did you receive first aid? \_\_\_\_\_ Were you seen by a nurse? \_\_\_\_\_ By Whom? \_\_\_\_\_ When? \_\_\_\_\_

Where? \_\_\_\_\_ Was 911 called? \_\_\_\_\_ Were you transported by ambulance? \_\_\_\_\_ Treated in an ER? \_\_\_ Where? \_\_\_\_\_

Hospitalized? \_\_\_\_\_ Have you missed time from work? \_\_\_\_\_ Dates \_\_\_\_\_ Were you seen by a physician? \_\_\_\_\_

Doctor: Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of Injured Person \_\_\_\_\_ Date \_\_\_\_\_ Signature of Supervisor/Principal/Manager \_\_\_\_\_ Date \_\_\_\_\_