

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 (Last, First, Middle): _____

SSN: ____-____-____ **DOB:** ____/____/____ **Sex:** M/F (circle one)

Address (Number & Street): _____

City: _____ State: _____ Zip: _____

Phone Number: ____-____-____ **Hire Date:** ____/____/____

Job Title: _____

Injury Report Information:

Job Location: _____

DISTRICT: _____

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: _____

(printed name and signature)

Phone Number: ____ - ____ - _____

Date: _____

Feedback: _____

Please return via email to Julie Powers jpowers@edustaff.org or via fax to 877-974-6339.

Thanks!