# EMPLOYEE FIRST REPORT OF INJURY

***To be completed and signed by employee and person receiving report***

***GENERAL INFORMATION***

Employee Name_____ Phone Number _____

Address _____

Social Security # _____Date of Birth_____ Employment Date_____

Job Title _____ Department _____ Sex (M/F) _____

***ACCIDENT INFORMATION***

Date of Accident _____ Time of Accident _____Where Did Accident Happen _____

*Detailed* Description of What Happened _____

_____

*Specifically* What You Were Doing, *(in detail)*_____

_____

Describe *Precisely* the Pain You Felt (sharp, dull), and Noise Heard (snap, pop, pull, sharp, from waist to knee, etc.)

_____

*Specific* Location of Pain (low back, right knee, etc.) _____

Nature of Injury (bruise, twist, cut, scratch broke skin?, etc.) _____

Did Accident Involve an Unsafe Act? Describe_____

Did Accident Involve an Unsafe Condition? Describe _____

_____

How Could Accident Have Been Prevented? _____

Medical Treatment? Name of Dr, Hospital, etc. _____

Did Accident Involve a District Policy? Describe _____

Names of Witnesses _____

Employee Signature _____ Name Printed _____

Date Reported _____ Date Received _____ Received By_____