

CENTRAL CITY PUBLIC SCHOOLS

(Completed by Injured Employee)

INCIDENT REPORT

Print Employee's Name: _____ Today's Date: _____

Phone# _____ Building Location: _____ Supervisor: _____

INCIDENT INFORMATION

Date of Injury: _____ Time _____ am ___ pm Date Reported _____

To whom reported? _____ Did you miss time from work for the injury? ___ Yes ___ No

If yes, give dates and times: _____

Returned to work? ___ Yes ___ No ___ Full Duty ___ Light Duty

If no, date expected to return? _____

What part of your body was injured? (Right leg, left arm) _____

What is the injury? (Cut, Sprain, Bruise) _____

Explain in detail how the injury occurred: _____

Where did the injury occur? (Physical location) _____

Any witnesses? ___ Yes ___ No **If yes**, give names: _____

Did you seek medical treatment? ___ Yes ___ No

If yes, give date & time: _____

Doctor's name: _____ Return visit date: _____

What type of treatment are you getting? _____

How are you getting along now? _____

Have you ever injured this part of your body before? ___ Yes ___ No

If yes, explain when, how, and to what extent: _____

What would you do to prevent this from happening again? _____

Signature of Employee: _____ Print Employee's Name _____