

EMPLOYEE INJURY REPORT
COLLINSVILLE COMMUNITY UNIT SCHOOL DISTRICT #10

Employee Name: _____ **Date of Report:** _____

Employee Address: _____
mailing address city state zip code

Home Telephone #: (_____) _____ **Date Employed:** _____

SS#: _____ **Date of Birth:** _____ **Male/Female:** _____

Married/Single/Widow/Divorced: _____ **# of Dependents:** _____

Date of Injury: _____ **Time of Injury:** _____ **AM or PM**

Job Title: _____ **School/Department:** _____

Address where incident occurred: _____

Type of Injury: _____

Part(s) of body affected (be specific): _____

How did accident occur? _____

What task were you performing when this occurred? _____

What hazardous or unsafe conditions contributed? _____

Have emergency medical services been rendered? _____ *(If not an emergency, please call the Administration Building for a referral)*

Date employee last worked: _____ **Has employee been hospitalized?** _____

Name/Address/Phone of Physician: _____

Name/Address of Hospital: _____

Will any days of work be lost as a result of this incident? _____

Employee Signature (or other designee completing this form) Date

Principal Signature (or other designee) Date

PLEASE SEND COMPLETED REPORT TO THE BUSINESS OFFICE WITHIN 24 HOURS