Caldwell ISD

EMPLOYEE'S REPORT OF INJURY / ILLNESS

(Form is to be filled out by supervisor only)

Injured's Name: _____ Date of Accident: _____
Address: _____ Time of Accident: _____
Phone: _____ Date of Birth: _____
S/S Number: _____ Male Female
Number of Dependents: _____ Marital Status: _____
Date Hire: _____
Occupation/Job Title: _____

Occurrence Information

Type of Claim: Near Miss Medical Only Lost Time
Date of Injury: _____ Time Employee Begins Work: _____
Time of Occurrence: _____ Date Employer Notified: _____
Last Work Date: _____
Date Disability Began: _____ Injury Report To: _____
Contact Phone Number: _____
Type of Injury: _____ Part of Body Affected: _____
Cause of Injury: _____
Did injury exposure occur on employer's premise? Yes No
Department and Location where accident occurred: _____
Equipment employee was using when accident illness occurred: _____
Activity employee was engaged in when the accident occurred (be specific):

Work process the employee was engaged in when accident occurred:

How did injury occur? _____
Describe the sequence of events that directly injured the employee: _____ _____ _____

Date returned to work: _____ If fatal, Give date of death: _____

Were Safeguards or safety equipment provided? Yes No
Were they used? Yes No
What preventative measures should be taken? _____
_____
_____

Other Information

Name of Witness: _____ Phone number: _____

Date Administrator notified: _____ Date prepared: _____

Prepared By: _____ Title: _____

Distribution: 1) Benefits Coordinator Amy Hejl 2) Director Of Business Heather Belyeu