

**BLOOMINGTON INDEPENDENT SCHOOL DISTRICT  
EMPLOYER'S FIRST REPORT OF INJURY**

NAME: \_\_\_\_\_ FEMALE \_\_\_\_\_ MALE \_\_\_\_\_

SSN: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_ DOB \_\_\_\_\_

DOES EMPL SPEAK ENGLISH? \_\_\_\_\_ IF NO, WHAT LANGUAGE? \_\_\_\_\_

EMPLOYEE'S MAILING ADDRESS: \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_ # OF DEPENDENT CHILDREN: \_\_\_\_\_

SPOUSE'S NAME: \_\_\_\_\_

DOCTOR'S NAME AND ADDRESS: \_\_\_\_\_

DATE OF INJURY: \_\_\_\_\_ TIME OF INJURY: \_\_\_\_\_ AM/PM

IS EMPLOYEE MISSING WORK DUE TO INJURY? \_\_\_\_\_

DATE LOST TIME BEGAN: \_\_\_\_\_

PART OF BODY INJURED: (BE SPECIFIC, IE. RIGHT FOREARM) \_\_\_\_\_

HOW ACCIDENT/INJURY OCCURRED: \_\_\_\_\_

OCCUPATION OF INJURED WORKER: \_\_\_\_\_

WAS EMPLOYEE DOING HIS/HER REGULAR JOB? \_\_\_\_\_

DID EMPLOYEE SEEK MEDICAL ATTENTION? \_\_\_\_\_

LENGTH OF SERVICE IN CURRENT POSITION: \_\_\_\_\_ YEARS \_\_\_\_\_ MONTHS

LENGTH OF SERVICE IN OCCUPATION: \_\_\_\_\_ YEARS \_\_\_\_\_ MONTHS

WORKSITE LOCATION OF INJURY (STAIRS, PARKING LOT, DOCK, CLASSROOM, ETC.) \_\_\_\_\_

WITNESSES: \_\_\_\_\_

DATE EMPL RETURN TO WORK/ OR EXPECTED DATE OF RETURN: \_\_\_\_\_

DATE ACCIDENT/INJURY REPORTED TO SUPERVISOR: \_\_\_\_\_

EMPLOYEE'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

SUPERVISOR'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**Please fill in all blanks and return to Janice Hayes within 24 hours of accident/injury.**