Menifee County School District

First Report of Injury or Illness

(To be completed immediately after accident.)

Employee Name:________________________________Date and Time of Injury:___________________

Job Title: ________________________________ Occupation when injured: ________________________

Job Location: ____

Nature and extent of injury: ____

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Type of Illness/Injury: ___________________________

Part of Body Affected: ___________________________ Right ☐ Left ☐

All Equipment, Materials, or Chemicals Employee was using when accident occurred: ________________

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Specific Activity Employee was engaged in when accident/injury occurred: _________________________

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Work Process the Employee was engaged in when accident/injury occurred: ________________________

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Description of accident. How injury/abnormal health condition occurred. Describe the sequence of events and include objects or substances that directly injured the employee or made employee ill:

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Were safeguards or Safety Equipment Provided? Yes ☐ No ☐ Were they used? Yes ☐ No ☐

Physician/Health Care Provider (Name & Address) Hospital (Name & Address)

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

Initial Treatment:

☐ No medical treatment ☐ Minor: By Employer (nurse) ☐ Minor: Clinic/Hosp. ☐ Emergency Care

☐ Hospitalized> 24 hr. ☐ Future Major Medical/Lost Time Anticipated

Witness to Accident (Name & Phone Number):____

Signature:______________________________________ Date:________________________________

Date Administrator Notified: ______________________