EMPLOYEE FIRST REPORT OF ILLNESS OR INJURY

Name: _____ ☐ Male ☐ Female Date of Birth ____-____-_____

Social Security No. _____-_____-_____ Date of Employment _____-_____-_____

Race: ☐ White ☐ Black ☐ Asian Ethnicity: ☐ Hispanic ☐ Native American ☐ Other

Home Address (street, city, zip): _____

_____

Home Phone: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Name: _____ Number of dependent children: _____

Does employee speak English? ☐ Yes ☐ No Work day begins at (time): _____

Date of Illness/Injury: _____ Time of Illness/Injury: _____

Date of lost time began: _____ Was employee doing regular job? ☐ Yes ☐ No

How and why illness/injury occurred: _____

_____

Part of body injured or exposed (ex. Left leg): _____

Nature of Injury (ex. Sprain): _____ Cause of injury (ex. Hit by student) _____

Worksite location of injury (ex. Stairs, classroom) _____

Name of business/location and address where illness/injury occurred: _____

_____

Has employee been exposed to blood borne pathogens (BBP) ☐ Yes ☐ No

Witnesses: (1) _____ (2) _____ (3)_____

Job title/position: _____

Supervisor: _____ Date supervisor informed: _____

Supervisor's signature: _____ Date: _____

I certify that the information contained in this report is true and correct. I understand that any falsification of information regarding an on the job injury may result in disciplinary action and/or prosecution under the appropriate State Criminal Statutes. I hereby authorize the release of all medical records relating to the above noted incident to my employer, his agent or insurance company.

Employee Signature: _____ Date: _____