Complete and Fax to Human Resources @ (940) 569-4776

EMPLOYEE FIRST REPORT OF INJURY REPORT

Name (Last, First, M.I.)			Date of Injury	Time of Injury AM / PM	Date Loss Time Began
Social Security #	Home Phone	Date of Birth	Nature of Injury – ***See List***	Cause of Injury – ***See List***	
Mailing Address Street or P.O. Box City, State Zip County			How and Why Injury/Illness Occurred		
Race:	Martial Status: Married, Widowed, Separated, Single, Divorced		Reason for Injury – ***See List***		
Number of Dependent Children	Spouse's Name		Main Part of Body Injured – ***See List***		
Does the employee speak English? Yes No	Sex of Employee Male Female		Specific Part of Body Injured – ***See List***		
Campus Name & Address Where Injury or Exposure Occurred			Location on Campus or worksite where injury occurred (cafeteria, custodial closet, classroom, stairs)		
			List Witnesses & Attach Witness Statements, Exh C		
			Return to Work Date/or Expected Date	Did Employee Die? ☐ Yes ☐ No	
Doctor's Name Mailing Address City, State, Zip			Supervisor's Name		
			Date Reported to supervisor(m-d-y)		

Nurse's Report

First Aid Administered:
Referred to:
Comments: Nurse's Signature _____ Date: _____

For Central Office Use:

Date of Hire:	Length of Service in Current Position Months _____ Years _____	Length of Service in Occupation Months _____ Years _____
Occupation of Worker	Rate of Pay at this Job Hourly _____ Weekly _____	Full Work Week is Hours _____ Days _____
Last Paycheck was: $ _____ for _____ Hours or _____ days		

Nature of Injury:
No Physical Injury
Amputation
Angina Pectoris
Burn
Concussion
Contusion
Crushing
Dislocation
Electric Shock
Enucleation
Foreign Body
Fracture
Freezing
Hearing Impairment
Heat Prostration
Hernia
Infection
Inflammation
Laceration
Myocardial Infarction
Poisoning, general, not OD
Puncture
Rupture
Severance
Sprain
Strain
Syncope
Asphyxiation
Vascular
Vision Loss
Multiple Physical Injuries

Cause of Injury:
Burn or Scald
Caught in, under or between
Cut, punctured, scrape injury by
Fall, slip or trip injury
Motor vehicle
Strain or injury by
Striking against or stepping on
Struck or injured by
Rubbed or abraded by
Miscellaneous causes

Reason for Injury
Abnormal Air Pressure
Absorption, Ingestion, Inhalation
Animal or insect
Broken glass
Caught in, under or between
Chemicals
Cold Objects or substances
Collapsing materials – slides of earth
Collision with another vehicle
Collision with a fixed object
Contact With, NOC
Continual noise
Crash of airplane
Crash of rail vehicle

Reason for Injury - continued:
Cumulative, NOC
Cut, puncture, scrape
Dust, gases, fumes, vapors
Electrical Current
Explosion or flare back
Fall, slip or trip, NOC
Falling or flying object
Fellow worker or other person
Fire or flame
Foreign matter in eye(s)
From Different Level, (elevation)
From ladder or scaffolding
From liquid or grease spills
Hand tool or maching in use
Hand tool, utensil – not powered
Holding or carrying
Hot objects or substances
Into Openings
Jumping or leaping
Lifting
Machine or machinery
Mold
Motor Vehicle
Motor Vehicle, NOC
Moving part(s) of machine
Natural Disaster
Object being lifted or handled
Object handled
Object handled by others
On ice or snow
On same level
On stairs
Other – Misc., NOC
Other than physical cause of injury
Person in act of a crime
Powered hand tool, appliance
Pushing or pulling
Radiation
Reaching
Repetitive motion
Rubbed or abraded, NOC
Sanding, scraping or cleaning
Slip or trip, did not fall
Stationary object
Steam or hot fluids
Stepping on sharp object
Strain or injury by, NOC
Striking against or stepping on, NOC
Struck or injured, NOC
Temperature extremes
Terrorism
Twisting
Using tool or machinery
Vehicle Upset
Welding operation
Wielding or throwing

Main Part of Body Injured:
Head
Neck
Upper Extremeties
Trunk
Lower Extremeties
Multiple Body Parts

Specific Part of Body Injured:
Abdomen including groin
Ankle
Artificial appliance
Body systems & mult. Body systems
Brain
Buttocks
Chest
Disc
Ear(s)
Elbow
Eye(s)
Facial bones
Finer(s)
Foot
Great toe
Hand
Heart
Hip
Internal organs
Knee
Larynx
Lower back area
Lower arm
Lower leg
Lumbar & sacral vertebrae
Lungs
Mouth
Multiple body parts
Multiple head injury
Multiple lower extremeties
Multiple injury
Multiple trunk
Multiple upper extremeties
No physical injury
Nose
Pelvis
Sacrum and coccyx
Shoulder(s)
Skull
Soft Tissue
Spinal Cord
Teeth
Thumb
Toe(s)
Trachea
Upper arm CL/SC
Upper back
Upper leg
Vertebrae
Whole body
Wrist
Wrist(s) & Hand(s)

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Employee's Injury Report

This form must be completed in detail and signed by the injured employee.

Your Full Name		Department You Work For
Social Security Number (Last 4 digits only) XXXX-XX-	Date of Birth	Location of Accident
Your Address (Street, City, State, County, Zip)		Supervisor's Name
Phone Number Where You Can be Reached		Job Title at Time of Injury
Date of Hire		How Long in Current Position Yrs. Mos.

Details of the Injury

Date of Injury	Time of Injury AM / PM	Date you first Lost Time
Where in the workplace did your injury occur?		
Describe in detail how your injury occurred.		
What safety equipment were you using at the time of the accident?		
What can be done to prevent this type of injury in the future?		

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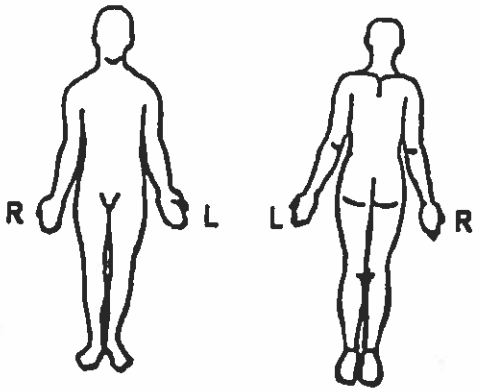
When were you first aware of this injury?	
When did you first notify your supervisor of your injury?	
What part of your body is injured?	Describe the injury.

On the diagram provided below, please circle the part(s) of your body where you are experiencing pain due to this injury.



Did anyone witness your accident? List the names of any witnesses.

Was anyone else injured in this accident? List the names of any other injured people.

In the incident that caused your injury, was there damage to any property or equipment? Describe any damage.

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's Printed Name	Employee's Signature	Date

I certify that the above employee has acknowledged to me that he/she understood all questions and signed and dated this form in my presence this date.

Witness' Printed Name	Witness' Signature	Date

EXHIBIT G

REPORT BY SAFETY PROGRAM ADVISORY COMMITTEE
OR SAFETY OFFICER

In reference to the incident/accident that occurred on _____(date), at _____(time) involving _____(name), the Safety Program Advisory/Safety Officer makes the following report:

Principal's or supervisor's recommendations for additional action _____

Comments and recommendations of the Safety Program Advisory Committee/Safety Officer _____

Additional actions to be taken _____

Deadline for these actions _____

_____
Safety Program Advisory Committee Chairman/Safety Officer

_____
Date

EXHIBIT C

WITNESS STATEMENT FORM: EMPLOYEE INCIDENT/ACCIDENT

Name of witness _____

Home address _____ Telephone _____

Business address _____ Telephone _____

Date of accident _____ Time occurred _____ ☐am ☐pm

Where did the accident happen? Be specific. _____

How close were you when the accident occurred? _____

Did you see it? _____ If not, how soon after the accident did you arrive? _____

Was anyone injured? _____ If so, who? _____

Were there other witnesses? _____ If yes, list names. _____

Describe what you saw and heard:

_____

Signature of witness_____ Date: _____

(Attach diagrams or additional sheets if needed.)