

## DECATUR PUBLIC SCHOOL DISTRICT 61 EMPLOYEE INJURY or ASSAULT\* REPORT

Complete this report immediately following a work injury or assault. Give original to building principal or administrator. The principal/administrator will disseminate the form to the proper parties (see reverse side). If reporting an assault, complete top portion and reverse side of this form.

*Print legibly in ink.*

Mr. Mrs. Ms.				(217)			
Name	Last	First	MI	Home Telephone	Date of Hire	Social Security Number (Required)	
Address			City/State/Zip				
F M							
Sex	Marital Status		Date of Birth		Number of Dependent Children		
Job Title			Hours Per Week		Regular or Special Education? (217)		
School/Building Base					Work Telephone		

***Complete the following section for an injury – report assault incident on reverse side of this form.***

Injury Date	Time	AM PM	Days missed work, if applicable:
Where did injury happen? (Address, building, area)			
Describe <u>what part of your body</u> was injured and <u>how it was injured</u> . Be specific: Part(s) of body injured, whether it was right or left; broken, sprained, etc.:			
What were you doing when accident occurred?			
Witnesses: List names and job titles of any witnesses to this accident.			
How did injury happen?			
In your opinion, what contributed to or caused the accident?			
What corrective action, if any, should be taken to avoid an injury of this kind again?			
Have you returned to work?	Date Returned	# of Work Days Missed	
Were medical services provided or do you plan to see a doctor?			
Physician's name and address:			
Were you hospitalized?	Hospital Name and Address		
Signature of Employee			Date
Supervisor Signature(s)			Date

**(\*OVER FOR ASSAULT CASE)**

**ASSAULT REPORT FORM**  
(To be completed by person assaulted)

Assault Date \_\_\_\_\_ Time \_\_\_\_\_ Assault Reported To: \_\_\_\_\_

Please provide a detailed description of the incident. Add pages as needed.

Action taken by Administrator:

Was incident filed with law enforcement authorities?

By Administrator	Yes _____	No _____
By Injured Party	Yes _____	No _____

Time Lost: Class \_\_\_\_\_ Days \_\_\_\_\_

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**Building Principal/Designee (please checkmark as executed)**

Send original\* to \_\_\_\_\_ Business Office – Keil Administration Building

Send copies to: \_\_\_\_\_ Building Records File  
\_\_\_\_\_ Union President  
\_\_\_\_\_ Assistant Superintendent of Schools  
\_\_\_\_\_ Police Department (mandatory for assault cases)

\*Send original and copies within 5 days of the incident.