

# DECATUR PUBLIC SCHOOL DISTRICT 61

## EMPLOYEE INJURY

Complete this report immediately following a work injury. Give original to building principal or administrator.

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		

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	