EMPLOYEE INJURY REPORT

COLLINSVILLE COMMUNITY UNIT SCHOOL DISTRICT #10

Complete form & click here to print

Employee Name:_____ **Date of Report:**_____

Employee Address: _____
mailing address city state zip code

Home Telephone #: (_____)_____ **Date Employed:**_____

SS#:_____ **Date of Birth:**_____ **Male/Female:**_____

Married/Single/Widow/Divorced:_____ **# of Dependents:**_____

Date of Injury:_____ **Time of Injury:**_____ ☐ **AM or** ☐ **PM**

Job Title:_____ **School/Department:**_____

Address where incident occurred:_____

Type of Injury:_____

_____

Part(s) of body affected ***(be specific)*****:**_____

How did accident occur?_____

_____

What task were you performing when this occurred?_____

_____

What hazardous or unsafe conditions contributed?_____

_____

Have emergency medical services been rendered?_____ *(If not an emergency, please call the Administration Building for a referral)*

Date employee last worked:_____ **Has employee been hospitalized?**_____

Name/Address/Phone of Physician:_____

Name/Address of Hospital:_____

Will any days of work be lost as a result of this incident?_____

_____ _____
Employee Signature (or other designee completing this form) Date

_____ _____
Principal Signature (or other designee) Date

PLEASE SEND* COMPLETED *REPORT TO THE BUSINESS OFFICE WITHIN 24 HOURS