Oyster River Cooperative School District - Injury Report

First Name _____ Last Name _____ Student Staff Visitor (Circle one)

Date of Birth _____ Gender _____

Street Address_____ City_____ State___ Zip_____

Phone Number_____

Date of Injury _____ Time of Injury _____Date Supervisor/Employer was first notified_____

Location of/Jobsite where accident occurred_____

Cause of Accident

_____

Describe fully how the accident occurred and what the employee was doing when injured.
(Please do not use actual employee names, refer to as “employee”, “subject”, “he”, “she”, etc.)

_____

_____

_____

_____

Name(s) of witnesses:

_____

Part(s) of body injured

_____

Did the employee seek medical attention? Y/N_____, if yes, please check appropriate box(es) below.

You must select at least 1 option below. If more than 1 option applies to this claim, please select all that apply.

Care provided by Employer only (on site) ☐

Emergency Care ☐

Hospitalized ☐

Other (Outpatient) ☐

Clinic ☐

Office Visit ☐

Other-Explain ☐

Treating Physician ☐

Treating Hospital ☐

Has the injured employee returned to work? _____

This report was completed by _____ Title _____

Employee Signature _____ Date_____

A copy of this form should be kept at the location where injury occurred. The original of this form and all other related documentation should be forwarded to the Personnel Clerk at the SAU office.

Authorized Signature _____ Date _____

Revised 6/24/20