EMPLOYEE TO COMPLETE

WAYNE COUNTY BOARD OF EDUCATION
EMPLOYEE REPORT OF INJURY/DESCRIPTION OF EVENT

☐Minor ☐ First Aid ☐Medical ☐ Illness ☐ Lost Work Day (Please mark all that apply)

Employee Name: ____ SS#:____

Home Address: ____
(Street) (City) (State) (Zip)

☐ Male ☐ Female Date of Birth: ___________________ Home Telephone _______________________________________

Date of Accident ___________________ Time _____________ ☐AM ☐PM

Date stopped work due to injury _________ Time Stopped work due to injury____________ ☐AM ☐PM

Regular work schedule: Start_________ ☐AM ☐PM Stop________ ☐AM ☐PM Occupation:_________________

Type of injury(s): (Check all that apply)

Cut ___	Amputation____	Burn (mild) ____	Abrasion ____	Fracture____	Contusion_____
Insect Bite___	Puncture ____	Electrical Shock____	Dislocation ____	Rupture____	Sprain/Strain___
Burn (moderate to severe) ____		Rash ____	Other: _____________		

Injured part of body: (Check all that apply)

RT	LT	RT	LT	RT	LT		
☐	☐ Eye	☐	☐ Wrist	☐	☐ Calf	☐ Head	☐ Abdomen
☐	☐ Collarbone	☐	☐ Hand	☐	☐ Knee	☐ Mouth	☐ Groin
☐	☐ Shoulder	☐	☐ Thumb	☐	☐ Ankle	☐ Teeth	☐ Finger
☐	☐ Arm	☐	☐ Hip	☐	☐ Foot	☐ Neck	☐ Toe
☐	☐ Elbow	☐	☐ Leg	☐	☐ Instep	☐ Nose	☐ Chest
☐	☐ Forearm	☐	☐ Thigh	☐	☐ Ribs	☐ Back	☐ Other_______

Identify which finger or toe injured: ________________________________

Describe the accident, explaining what you were doing, how you were doing it, where you were, etc. (Including equipment, material and/or chemicals being used: ____
____
____

Nature of Event:

Fall (Same level) _____	Caught In _____	Struck By ____	Exposure _____
Fall (Up different level) _____	Caught On _____	Struck Against ____	Hand Tool _____
Slip/Trip _____	Stepped in hole _____	Chemical Agent ____	Hot Surface _____
Cutting Edge _____	Falling Object _____	Inhalation ____	Other: ______________

WITNESSES:	Name	Address	Telephone #
	________________	________________	________________
	________________	________________	________________
	________________	________________	________________

Do you anticipate seeking medical attention? ________________ Name of medical facility __________________________________

SIGNATURE OF EMPLOYEE: _________________________________ DATE: _________________________________

ACCIDENT MUST BE REPORTERD IMMEDIATELY TO YOUR IMMEDIATE SUPERVISOR. INJURY REPORT, INVESTIGATION REPORT AND WITNESS REPORTS MUST BE SENT TO ATTN:SAFETY DIRECTOR, WITHIN 24 HOURS OF ACCIDENT!! 304-272-5519fax