Employee Injury Report

Please complete this form and send it to Risk Management Services on the date of injury, even if your supervisor has not yet signed the form. Send completed form through District mail. <u>If medical care is needed, it must be obtained from a designated medical provider</u>. If you have questions, call Risk Management at 303-682-7428.

Employee Name: ____ Job title: _____________________________
School/Department: __________________________________ Supervisor: ___________________________
Social Security Number: _______________________________ District ID: ___________________________
Home Address: ____ City: ____________________ Zip: ___________
Cell phone number: __________________________ Home phone number: _______________________________
Personal Email: ________________________________ Date of Birth: __________________ Gender: __________
Marital Status: ❑Married ❑Single ❑Divorced ❑Widowed Number of dependents: __________
❑ Full Time ❑ Part Time ❑ Sub ❑ Seasonal/temp ❑ 110 ❑Other ________________ Date of Hire: ___________
Wage rate: ____________Hours/week: __________ Language preference (if not English): ___________________

Injury information

Date of injury: ____________ Time of injury: _________ ❑ AM ❑ PM Date reported to supervisor: ____________
Did this injury aggravate a previous condition or injury of some body part? ❑ Yes ❑ No

Type of Injury:	**Body Part Injured (Specify "Right" or "Left"):**	
□ Abrasion/Cut/Puncture	□ Head	□ Back
□ Bruise	□ Neck	□ Chest/Abdomen
□ Burn	□ Shoulder	□ Leg
□ Fracture/Dislocation	□ Arm	□ Knee
□ Sprain/Strain	□ Wrist	□ Foot/Ankle
□ Other ________________________	□ Hand/Fingers	□ Other: _____________________

What were you doing when you were hurt? ____
Describe how injury occurred: ____
____
____
____
Witnesses: ____
Do you need medical attention? ❑ Yes ❑ No ❑ I might, but I am waiting to see how I do
Did you already go to the doctor? ❑ Yes ❑ No If yes, where? ____
Make any suggestions that could prevent a future injury: ____
____

____ ____
Employee signature Date Principal/Supervisor signature Date

RISK MANAGEMENT USE ONLY

Received: ___________________________ DOH: ___________________________________
DMP:_______________________________ ID: _____________________________________
Log: ________________________________ Claim: __________________________________