



Employee Injury / Illness Report

Date of Injury ____ / ____ / ____

EMPLOYEE INFORMATION

First Name _____ Middle Name/Initial _____

Last Name _____ Suffix _____

Mailing Address _____

City _____ State _____ Postal Code _____ Country _____

Phone Number (____) _____ - _____ Date of Birth ____ / ____ / ____ Date of Hire ____ / ____ / ____

Gender Male Female X Unknown

Employee SSN _____

Job Title _____

Employee Email Address _____

CLAIM INFORMATION

Time of Injury ____ : ____ AM PM Date Employer Had Knowledge of the Injury ____ / ____ / ____

Employment Status: Full-time Part-time Date Employer Had Knowledge of Date of Disability ____ / ____ / ____

Estimated Weekly Wage \$ _____ Number of Days Worked Per Week _____

Work Week Type Standard Work Week Fixed Work Week Varied Work Week

Work Days Scheduled Sun Mon Tues Wed Thurs Fri Sat



EMPLOYEE INJURY

Full Wages Paid for Date of Injury Yes No Employer Paid Salary in Lieu of Compensation Yes No

Initial Treatment No Medical Treatment Minor On-Site Treatment By Employer Minor Clinic/Hospital Treatment

Emergency Evaluation Hospitalization Greater Than 24 Hours Future Major Medical/Lost Time Anticipated

Death Result of Injury Yes No Unknown Date of Death ___/___/___ Number of Dependents _____

Nature of Injury (i.e. Laceration, Burns, Fracture, Strain, etc.) _____

Part of Body (i.e. left arm, right foot, head, multiple, etc.) _____

Cause of Injury (i.e. Motor Vehicle, Machine, Strain or Injury by lifting, etc.) _____

Accident/Injury Description (describe how the accident occurred and resulting injuries) _____

WORK STATUS

Initial Date Last Day Worked ___/___/___

Return to Work Type Actual Released

Initial Date Disability Began ___/___/___

Physical Restrictions Yes No

Initial Return to Work Date ___/___/___

Return to Work Type Yes No

ACCIDENT LOCATION AND WITNESSES

PREMISES (where injury occurred)

Organization Name: Berlin Central School District

Building MS/HS BES BUS GARAGE

OTHER _____

Street Address _____

State _____

City _____

Postal Code _____

Specific Location (i.e. under bleachers, lower soccer field, etc.) _____



WITNESSES

Names

Phone number

() - _____

() - _____

() - _____

Employee Signature: _____

Date ____/____/____

***** Give form to your Supervisor *****

ADMINISTRATOR REVIEW

Date / Time you were notified of the injury / illness: ____/____/____

AM
 PM

Root Cause of injury/illness:

Action(s) taken:

Administrator name (Print): _____

Administrator signature: _____

Date ____/____/____