Raymond School District's Employee's First Report of Injury *

Name: _____ Last 4 digits of your SS #: _____

If your mailing address and/or phone number has changed, enter the new information below.

_____

street city state zip phone number

Date of Injury	Time of Injury	Date Reported	Time Reported
/ /	☐ AM ☐ PM	/ /	☐ AM ☐ PM

To whom was the injury reported: _____

Name(s) of witnesses: _____

Name of your Principal/Director: _____

Job Title when injured: _____

Did this injury happen when you were doing your regular work? ☐ Yes ☐ No

Building the injury took place ☐ SAU ☐ RHS ☐ IHGMS ☐ LRES ☐ Other If other explain where below

_____

Exact room or area the injury took place _____
side parking lot, hallway near front office, room 101, etc

Body part(s) injured? _____ Symptoms of this injury? _____
none, left leg, left ear, lower back, etc none, pain, bleeding, bruise, etc

Have you had this type of injury before? ☐ Yes If yes, please explain _____ ☐ No

Do you have another employer ☐ Yes If yes, complete the next line ☐ No

_____
Name and address of other Employer Name of your Supervisor Phone number

Have you or do you plan to seek medical treatment for this injury? ☐ Yes If yes, complete the next line ☐ No

_____
Medical provider's name and address Phone number

Due to this injury, did you miss time from work? ☐ Yes If yes, date first missed work ____/____/____ ☐ No

Explain fully how this injury happened: _____

_____

_____

Signature: _____ Date: ____/____/____

* The information included on this form is reported to the District's workers' compensation insurance carrier.

Appendix A