

RH SCHOOLS EMPLOYEE INCIDENT REPORT

(Please Answer Every Question)

Your Name: _____
First Middle Last

Your Employer's Name and Location: _____

Your Address: _____
Street City State Zip

Telephone Number: _____ Social Security: _____ Age: _____

Date of Birth: _____ Job/Position Title: _____ Hire Date: _____

Time Shift Starts: _____ Time Shift Ends: _____ FT/PT: _____

Date of Injury: _____ Time of Injury: _____ am _____ pm

Specific location where injury occurred (ex. classroom, stairs, gym): _____

Describe how you were injured: _____

Describe the type of injury (ex. bruise, contusion, strain, sprain, etc.) _____

Did your injury occur from one specific incident? _____ If yes, explain in detail. _____

Did your injury develop gradually over a period of time? _____ If yes, indicate period of time:

From: _____ To: _____ Describe how injury developed. _____
Date Time Date Time

Is there any way, other than described above, that you possibly could have injured yourself?
Yes _____ No _____ If so, please give details.

Explain what caused your injury: (Example: What caused you to fall?) _____

If you were lifting or moving an object when you were injured, describe the object: _____

_____ Give the approximate weight of the object: _____

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Describe the position you were in when you were injured: (Example: Sitting, Standing, Squatting, Bending)

When did you first realize you were injured? _____ **When did you first feel the**
Date Time

pain? _____ **Who at work did you first tell about your injury?** _____
Date Time

_____ **When did you tell them?** _____ **When did you**
Date Time

first tell your immediate supervisor of your injury? _____ **Name of your supervisor**
Date Time

you reported your injury to: _____ **If injury was not reported**

to your supervisor on the date you were injured, state the reason it was not reported: _____

Name(s) of person(s) who witnessed your injury: _____

List parts of your body injured: _____

Names & Addresses of Physician(s) who have treated you for this injury:

Name & Address of Hospital: _____

Have you lost time from work due to this injury? ____ **If so, indicate the first day you missed from**
Yes No

work? _____ **If so, indicate the date you returned to work after this injury?** _____

Additional Remarks: _____

*** I certify that the answers given to the questions on both pages (2) of this Incident Report are correct and accurate to the best of my ability and recollection.**

Employee Signature

Date