INDEPENDENT SCHOOL DISTRICT 196
Rosemount-Apple Valley-Eagan Public Schools
Educating our students to reach their full potential

Series Number **406.7.1P** Adopted **July 1980** Revised **August 2013**

Title **Supervisor's Report of Employee Injury**

This form is to be completed for each occurrence of employee injury or work related illness and submitted to the Payroll Department via fax # 651-423-7788 within 24 hours of the incident.

Employee name _____ Employee number _____

Job Title _____ School/Building _____

Date of incident _____ Time employee started work _____ Time of incident _____

What date did employee first report injury/illness? _____ Reported to _____

Part(s) of Body Involved (please circle R for right or L for left as appropriate)

☐ abdomen/groin ☐ ankle (R/L) ☐ arm (R/L) ☐ back ☐ chest/rib ☐ ear (R/L) ☐ elbow (R/L)
☐ eye (R/L) ☐ face ☐ finger/thumb ☐ foot/toes (R/L) ☐ forehead ☐ hand (R/L) ☐ head
☐ hip (R/L) ☐ knee (R/L) ☐ leg (R/L) ☐ mouth ☐ neck ☐ nose ☐ side (R/L)
☐ shoulder (R/L) ☐ wrist (R/L) ☐ other _____

Nature of Injury/Illness

☐ abrasion/scratch (skin not broken) ☐ bruise ☐ burn ☐ choking ☐ concussion ☐ dermatitis
☐ dislocation ☐ fracture ☐ hearing ☐ infection ☐ laceration/cut ☐ poisoning
☐ repetitive/cumulative ☐ respiratory ☐ skin punctured ☐ sprain/strain ☐ vision impaired
☐ other _____

Where and How Injury/Incident Occurred

Did injury/incident occur on District 196 property? ☐ yes ☐ no

If yes: What school/building? _____ Where on property? _____

If no: Name and address of location: _____

How did the injury/incident occur and what was employee doing before incident (give details)? _____

_____

_____

Describe the injury/incident in detail: _____

_____

What, if any, tools, equipment, objects or substances were involved? _____

_____

Action Taken and Follow Up

What, if any, first aid treatment was given? _____

_____

Employee: ☐ returned to work within ___ minutes or ___ hours ☐ left work at _____ (time & date) and returned _____ (time & date)

Did employee go or plan to go to a medical provider? ☐ yes ☐ no If yes, complete the following:

Name of clinic/hospital: _____

Name of medical provider: _____ Ambulance transport? ☐ yes ☐ no

Address: _____ Emergency room visit? ☐ yes ☐ no

_____ Overnight stay in hospital? ☐ yes ☐ no

Phone: _____

_____ _____
Witness name and job title Witness phone #

_____ _____
Supervisor or school nurse completing report Date

_____ _____
Principal/administrator signature Date signed

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