LAKOTA LOCAL SCHOOLS

EMPLOYEE INJURY REPORT

*INSTRUCTIONS: To be completed by employee within 24 hours of injury and investigated by his/her immediate supervisor and forwarded to the Treasurer's Office within 48 hours.*

**ALL SECTIONS MUST BE COMPLETED IN FULL OR REPORT WILL BE RETURNED**

**EMPLOYEE INFORMATION (TO BE COMPLETED BY EMPLOYEE)**

Name _____ Employee ID # _____

Address _____ City _____ Zip _____ Phone _____

Date of Birth _____ Age _____ Marital Status _____

Sex _____ Building _____ Job Title _____

Hire Date _____ Time Shift Started _____

**INJURY/TREATMENT INFORMATION (TO BE COMPLETED BY EMPLOYEE)**

Date of Injury _____ Time of Injury _____

Date Reported & To Whom _____

Where Did the Injury Occur _____

Body Part Injured _____

What Caused the Injury _____

Was Medical Treatment Required _____ Name of Doctor/Hospital _____

Address _____ Phone No. _____

Describe Treatment _____

Will Injury Cause Any Missed Days _____ Last Date Worked _____

Expected Return to Work Date _____

Name(s) of Witnesses: _____

_____

_____

**ALL SECTIONS MUST BE COMPLETED IN FULL OR REPORT WILL BE RETURNED**

**DETAILED ACCIDENT DESCRIPTION (TO BE COMPLETED BY EMPLOYEE)**

Injured Employee _____

Fully Describe Accident:

_____

_____

_____

_____

_____

_____

Employee Signature _____ Date _____

**ADMINISTRATOR REVIEW**

**ADMINISTRATOR'S APPRAISAL AND INVESTIGATION (ATTACH WITNESS STATEMENTS, PHOTOS OF ACCIDENT SCENE AND COLLABORATING INFORMATION)**

What Factors Led to Accident: _____

_____

_____

_____

Recommendation and Certification (Approve/Disapprove/Comments): _____

_____

_____

_____

Has Employee Returned to Work? Y N Date or Expected Date of Return _____

Administrator's Signature _____ Date _____

**PLEASE ATTACH ALL DOCTORS' STATEMENTS TO INJURY REPORT**