

LEBANON SPECIAL SCHOOL DISTRICT

EMPLOYERS FIRST REPORT OF WORK INJURY AND ILLNESS

EMPLOYEE

Name Social Security Number Date & Time of Injury
Address Date of Birth
Telephone Number Date of Hire Gender Marital Status
Employee Status: Full-time/Regular Part-time Other:

WAGE

\$ Hourly Daily Weekly Bi-Weekly Monthly
Number of Days Worked Per Week: Full Wages Paid for Date of Injury YES NO

ACCIDENT/INJURY

Date Employer Notified of Injury Date Last Day Worked Date Disability Began Date Return to Work
NA NA

Address Where Injury Occurred Time Employee Began Work on Injury Date

Body Part Affected (i.e. leg, arm, wrist) Nature of Injury (i.e. burn, cut, strain)

Describe how accident or injury occurred. Describe accident including what the employee was doing just before, the part of the body affected and how, and object or substance that directly harmed the employee.

Empty lines for accident description.

Initial Treatment: No Medical Treatment Minor by Employer Minor by Clinic/Hospital Hospitalized > 24 Hrs. Emergency Care Future Major Medical/Lost Time Anticipated

OTHER

Signature of Person Filing Report Date

NOTE: REPORT SHOULD BE SENT TO THE DIRECTOR'S OFFICE IMMEDIATELY.

Date Received at Central Office Director/Designee's Signature Date

Revised 08/07