

Troy Area School District
Report of Occupational Injury
EMPLOYEE

Employee Information

Employee Last Name: _____ First Name: _____

Employee Home Address: _____

Marital Status: Single/Married Social Security Number: ____/____/____

No of Dependents: _____ Date of Birth: ____/____/____

Home Phone: _____ Job Classification/Title: _____

Injury Information

Location where injury occurred: _____

Date of Injury: ____/____/____ Time: ____ am/pm Time began work ____ am/pm

Did the employee return to work the same day as injury occurred? _____

Area(s) Injured: Please circle

Ankle	l/r	Arm	l/r	Ear	l/r
Elbow	l/r	Eye	l/r	Finger	l/r
Foot	l/r	Hand	l/r	Hip	l/r
Knee	l/r	Leg	l/r	Shoulder	l/r
Toes	l/r	Wrist	l/r	Abdomen	
Chest		Face		Head	
Mouth		Neck		Nose	
Teeth		Spine			

Type of Injury (Sprain, bruise etc): _____

Describe the cause of injury along with sequence of events resulting in injury. Include any objects or substances directly responsible: _____

Were safeguards or safety equipment provided? Yes/No

Were safeguards used? Yes/No

Witness Name: _____

Medical Treatment Information

No medical treatment _____

Minor by employee _____

Clinic/Hospital _____

Employee Physician _____

Emergency care _____

Hospitalized more than 24 hours _____

Name of Physician/Health Care Provider: _____

Address: _____

Name of hospital: _____