DANVILLE SCHOOL DISTRICT #118
FIRST REPORT OF INJURY

Fax Report to:
Kim Runyan, Benefits Coordinator 217.444.1043

Employee Incident Section

Employee's Full Name (Last, First, Middle Initial)	Home Phone	Social Security #	Birthdate	Job Title or Occupation

Employee's Street Address	City	State	Zip Code	Male / Female Married / Single / Separated

Number of Dependents	Date of Hire	Time Employee Began Work AM/PM	Date and Time of Accident	Employment Status Full-Time / Part-Time / Other

How were you injured? (Describe what you were doing)

Describe what part(s) of your body were hurt. (Be specific; left or right, upper and lower, etc.)

Date Accident was Reported	To Whom	Who was present when this accident happened?

Have you ever injured this part of your body before? YES / NO	If yes, please describe.
Employee Signature	Date Completed

Supervisor's Investigation Section

Do you question the legitimacy of this injury? YES/NO	If yes, why?

What actions are needed to prevent future injury?

Date preventative action taken?

Who was present at time of injury?	Witness Phone Number

Signature & Title	Phone #	Date Completed

Employer Section

Employer's Name	County of Accident Site	Was employee's salary continued in lieu of compensation? YES / NO

Employer's Mailing Address	City	State	Zip Code

Is this a lost work day case? YES / NO	Last Day Employee Worked	Was the employee paid for the date of the injury? YES / NO	Has Employee Returned to Work? YES / NO If Yes: Date: Lt Duty / Reg Duty

First 4 Scheduled Days Missed	Wage (Hourly, Weekly, Monthly)	Did the accident occur on the employer's premises? YES / NO

Employment Status Employee / Volunteer	Did employee receive medical treatment outside the worksite? YES / NO	Was employee treated in an emergency room? YES / NO	Was employee hospitalized? YES / NO

Name of Physician / Healthcare Professional	Phone #	Address (Street, City, State, Zip)

Name of Hospital	Phone #	Address (Street, City, State, Zip)

Report Prepared by (Signature and Title)	Phone #	Date Completed