DANVILLE SCHOOL DISTRICT #118
FIRST REPORT OF INJURY

Fax Report to:
Kim Hoffman, 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	☐ 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 ☐ Other (Describe below) ☐ Part-Time

How were you injured?

What were you doing at the time of injury?

What specifically caused your injury?

If injury was due to another human, what were they doing at the time?

If injury was due to a fall, were you carrying anything and if so, what?

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

BODY PART

☐ HEAD ☐ FACE ☐ NECK ☐ ABDOMEN ☐ CHEST ☐ GROIN

EYES:	☐ Left	☐ Right	☐ Both
EARS:	☐ Left	☐ Right	☐ Both
BACK:	☐ Upper	☐ Middle	☐ Lower
ARM:	☐ Left	☐ Right	☐ Both
SHOULDER:	☐ Left	☐ Right	☐ Both
ELBOW:	☐ Left	☐ Right	☐ Both
HAND:	☐ Left	☐ Right	☐ Both
WRIST:	☐ Left	☐ Right	☐ Both
FINGERS:			
LEG:	☐ Left	☐ Right	☐ Both
KNEE:	☐ Left	☐ Right	☐ Both
ANKLE:	☐ Left	☐ Right	☐ Both
FOOT:	☐ Left	☐ Right	☐ Both
TOES:			
OTHER:			

TYPE OF INJURY / OCCURANCE

- ☐ Student Related
- ☐ Pushing/Pulling
- ☐ Bending
- ☐ Slipped/Fall
- ☐ Lifting
- ☐ Struck By
- ☐ Sharp Object/Other
- ☐ Temperature Contact
- ☐ Needlestick/Contaminated
- ☐ Other ____________

What is your injury to this area? (scratch, bruise, cut, bite, 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: ☐ Light Duty ☐ Regular 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	