EMPLOYEE'S REPORT OF WORKPLACE INJURY

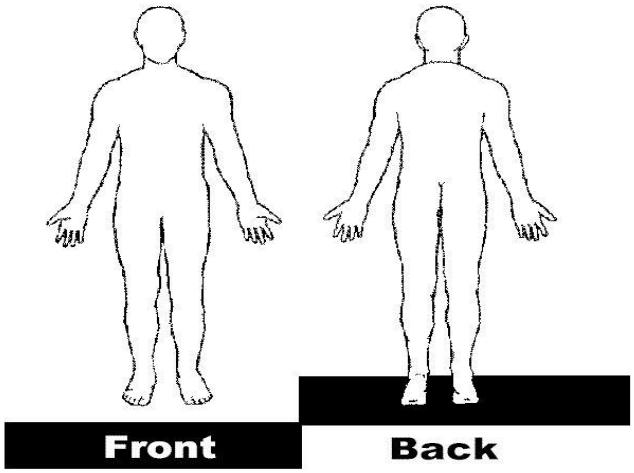
Complete and submit this form to your Supervisor within 24 hours of incident.

Employee Name _____ **Today's Date** _____

Date of Incident _____ **Time of Incident** _____ **Date Nurse Line (1-844-847-8708) Called** _____

Building/Site _____ **Exact Location of Incident (parking lot, east hallyway, etc)** _____

Indicate/shade part of body affected.



List any prior injuries to the same body part:

_____

Please check all that apply at the time of injury.

	Please check if items below were available.	Were you using item? YES	NO
Behavior Plan	❑	❑	❑
Kevlar sleeve	❑	❑	❑
PCM Training	❑	❑	❑
Protective baseball hat	❑	❑	❑
Protective beanie hat	❑	❑	❑
Walkie-talkie/radio	❑	❑	❑
Wearing closed toe shoes	❑	❑	❑
Other personal protective gear. Please list:	❑	❑	❑

_____

_____

Describe, step-by-step the events that led up to the injury. List any furniture, parts, objects, materials or other important details. Please use "student" or initials for others involved.

_____

_____

_____

_____

_____

❑ Description continued on attached sheet.

Name(s) of Witness(es) _____

Employee Signature _____ **Date** _____