

**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		<input type="checkbox"/> Male <input type="checkbox"/> Married	<input type="checkbox"/> Female <input type="checkbox"/> Single <input type="checkbox"/> Separated
Number of Dependents	Date of Hire	Time Employee Began Work <input type="checkbox"/> AM <input type="checkbox"/> PM	Date and Time of Accident	Employment Status <input type="checkbox"/> Full-Time <input type="checkbox"/> Other (Describe below) <input type="checkbox"/> 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	TYPE OF INJURY / OCCURANCE
<input type="checkbox"/> HEAD	<input type="checkbox"/> Student Related
<input type="checkbox"/> FACE	<input type="checkbox"/> Pushing/Pulling
<input type="checkbox"/> NECK	<input type="checkbox"/> Bending
<input type="checkbox"/> ABDOMEN	<input type="checkbox"/> Slipped/Fall
<input type="checkbox"/> CHEST	<input type="checkbox"/> Lifting
<input type="checkbox"/> GROIN	<input type="checkbox"/> Struck By
EYES: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both	<input type="checkbox"/> Sharp Object/Other
EARS: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both	<input type="checkbox"/> Temperature Contact
BACK: <input type="checkbox"/> Upper <input type="checkbox"/> Middle <input type="checkbox"/> Lower	<input type="checkbox"/> Needlestick/Contaminated
ARM: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both	<input type="checkbox"/> Other _____
SHOULDER: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both	
ELBOW: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both	
HAND: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both	
WRIST: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both	
FINGERS: _____	
LEG: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both	
KNEE: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both	
ANKLE: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both	
FOOT: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both	
TOES: _____	
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? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please describe.
Employee Signature		Date Completed

Supervisor's Investigation Section

Do you question the legitimacy of this injury? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Employer's Mailing Address		City		State	Zip Code
Is this a lost work day case? <input type="checkbox"/> Yes <input type="checkbox"/> No	Last Day Employee Worked	Was the employee paid for the date of the injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		Has Employee Returned to Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
				If Yes: Date: <input type="checkbox"/> Light Duty <input type="checkbox"/> Regular Duty	
First 4 Scheduled Days Missed		Wage <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly		Did the accident occur on the employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employment Status <input type="checkbox"/> Employee <input type="checkbox"/> Volunteer	Did employee receive medical treatment outside the worksite? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was employee treated in an emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No		Was employee hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> 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		