



MOUNT VERNON SCHOOL DISTRICT NO. 320

# EMPLOYEE INJURY REPORT

Today's Date: \_\_\_\_\_ Date of injury: \_\_\_\_\_ Date hired \_\_\_\_\_

Injured employee: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Male \_\_\_ Female \_\_\_ X

Address: \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Scheduled work days and hours: \_\_\_\_\_ Time of injury? \_\_\_\_\_ AM/PM

School/Site: \_\_\_\_\_ Position (teacher/IA, etc): \_\_\_\_\_

Exact location of injury (playground, classroom, etc.) \_\_\_\_\_

<u>Part of body Injured (circle Right/Left)</u>		<u>Type of Injury:</u>		<u>Response/Result:</u>	
<input type="checkbox"/> Head	<input type="checkbox"/> R. L. Hand	<input type="checkbox"/> Wounds	<input type="checkbox"/> Amputation	<input type="checkbox"/> Death	<input type="checkbox"/> Time Loss
<input type="checkbox"/> R. L. Eye	<input type="checkbox"/> R. L. Leg	<input type="checkbox"/> Strain & Sprain	<input type="checkbox"/> Burns	<input type="checkbox"/> First-Aid Only	
<input type="checkbox"/> Trunk	<input type="checkbox"/> R. L. Toe	<input type="checkbox"/> Hernia	<input type="checkbox"/> Foreign Body	<input type="checkbox"/> Sought Immediate Medical Treatment	
<input type="checkbox"/> R. L. Arm	<input type="checkbox"/> Internal	<input type="checkbox"/> Fracture	<input type="checkbox"/> Skin (occupational)	<input type="checkbox"/> Delayed Medical Treatment	

Remarks: \_\_\_\_\_ Remarks: \_\_\_\_\_ Remarks: \_\_\_\_\_

**I. Eyewitness(es) (Please request they complete the Statement of Witness Form):**

**II. DESCRIBE ACCIDENT:** Include the machine, equipment, object or substance involved. *ALL DETAILS...*

**III. CAUSE:** Mark basic cause

**UNSAFE CONDITIONS**

- Inadequately guarded
- Unguarded
- Defective tools, equipment or substance
- Unsafe design or construction
- Hazardous arrangement
- Unsafe illumination
- Unsafe ventilation
- Unsafe clothing
- Insufficient instruction

Mark contributing cause, if any

**UNSAFE ACTS**

- Operating without authority
- Operating at unsafe speed
- Making safety devices inoperative
- Using unsafe equipment or equipment unsafely
- Unsafe loading, placing, mixing
- Taking unsafe position
- Working on moving or dangerous equipment
- Distraction, teasing, horse play
- Failure to use personal protective devices

Why was the unsafe act committed? \_\_\_\_\_

Why did the unsafe condition exist? \_\_\_\_\_

Any physical disabilities? \_\_\_\_\_ Number of previous disability injuries (L & I)? \_\_\_\_\_

**IV. GUIDES TO CORRECTIVE ACTION**

Based on the cause checked above, I am taking the following corrective action:

**UNSAFE ACT**

- Stop the worker
- Study the job
- Instruct (tell-show-try-check)
- Follow-up
- Enforce

**UNSAFE CONDITION** If supervisor can't handle, then recommend to:

- |                                      |   |
|--------------------------------------|---|
| <input type="checkbox"/> Remove      | <input type="checkbox"/> Administrator        |
| <input type="checkbox"/> Guard       | <input type="checkbox"/> Safety Committee, or |
| <input type="checkbox"/> Warn        | <input type="checkbox"/> Maintenance dept. or |
| <input type="checkbox"/> Supervisory | <input type="checkbox"/> _____                |
| <input type="checkbox"/> Training    | <input type="checkbox"/> Follow-up            |

What I am actually doing to prevent similar injuries : \_\_\_\_\_

What further recommendations, if any : \_\_\_\_\_

**MOUNT VERNON SCHOOL DISTRICT NO. 320  
EMPLOYEE INJURY REPORT**

**V. DETAILED ACCIDENT INFORMATION**

**What was the employee doing just before the incident occurred?** Describe the activity, as well as the tools, equipment or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry", etc.

---



---

**What happened?** Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "worker was sprayed with chlorine when gasket broke during replacement"; "worker developed soreness in wrist over time", etc.

---



---

**What was the injury or illness?** Tell us the part of the body that was affected and how it was affected; be more specific than "hurt", "pain" or "sore". Examples: "strained back"; "chemical burn on hand"; "carpal tunnel syndrome", etc.

---



---

**What object or substance directly harmed the employee?** Examples: "concrete floor"; "chlorine"; "radial arm saw". If this question does not apply to the incident, please leave it blank.

---

If the employee died, when did death occur? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
month                      day                      year

**VI. TREATMENT RESPONSE**

Name of person who administered first aid: \_\_\_\_\_

If treatment was given away from the work-site, when was it given? Date & time \_\_\_\_\_

\*Facility: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Was employee treated in an emergency room? Yes \_\_\_\_\_ No \_\_\_\_\_

Was employee hospitalized overnight as an in-patient? Yes \_\_\_\_\_ No \_\_\_\_\_

Was employee put on any restrictions? Yes \_\_\_\_\_ No \_\_\_\_\_

**\*Complete Employee Return to Work Status Form and attach APF**

**Information about the case:** Case number from L&I Report \_\_\_\_\_

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervisor's Signature

\_\_\_\_\_  
Date