



Staff Member's First Report of Injury

PLEASE PRINT: This form must be filled in completely and accurately no later than 1 business day from the injury date and submitted to benefitsandleaves@springisd.org. Supervisor's Report should also be submitted.

Last Name: _____ First: _____ MI: _____

Mailing address: _____

City: _____ State: _____ Zip Code: _____

Primary Contact Phone (including area code): _____

Gender: ☐ Male ☐ Female Social Security Number: _____

Date of Birth: _____ Employee ID: _____

Will staff member seek medical attention from a physician? ☐ Yes ☐ No

(If yes) Physician Name: _____

Address: _____

Physician Office Phone: _____

Occupation of injured worker: _____

Date of injury: _____ Time of injury: _____ AM/PM

Nature of injury (cut, bruise, pain, etc): _____

Injured what body part: _____ ☐ Right ☐ Left (Check one, if applicable)

Location where accident happened (building/campus): _____

Where did the accident happen (stairs, hallway, classroom, etc): _____

Was staff member doing his/her job? ☐ Yes ☐ No What caused injury (fall, tool, etc): _____

Describe the accident in detail: _____

What could staff member have done to avoid the accident? _____

Witnesses (print first and last name): _____

Printed name of person filling out form: _____

Staff Member's Signature

Date

Supervisor's Signature

Date Reported