16717 Ella Blvd.
Houston, Texas 77090
Fax: 281-891-6041
www.springisd.org

Staff Member's First Report of Injury

PLEASE PRINT
This form must be filled in completely & accurately. This form will be submitted electronically

Last Name: _____ First: _____ MI: _____

Mailing address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Primary contact phone number (please include area code): _____

Gender: ☐ Male ☐ Female Social Security Number: _____

Date of Birth: _____ Race: ☐ White ☐ Black ☐ Asian ☐ Hispanic ☐ Other: _____

Did staff member seek medical attention from a physician? ☐ YES ☐ NO

(If yes) Physician name: _____

Mailing address: _____

Physician Office phone number: _____

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)

Building/Campus where accident happened _____

Exactly where did the accident happen (stairs, hallway, classroom, etc.)? _____

Was staff member doing his/her regular job? ☐ YES ☐ NO What caused injury (fall, tool, etc.)? _____

Describe the accident in detail: _____

_____

_____ (continue on back, if needed)

What could staff member have done to avoid the accident?

_____

Witnesses: _____

Printed name of person filling out form: _____

Staff member' signature	Date	Supervisor's signature	Date reported