FIRST REPORT OF INJURY **JORDAN SCHOOL DISTRICT**

Please complete and return to **Insurance within 3 days of injury.** DP346 Industrial Accidents

EMPLOYEE INFORMATION

Injured Employee Name _____ Date of Birth _____

Address_____City, State and Zipcode _____

Phone Number (_____) _____ Marital Status _____ Number of Dependents _____

Hired Date _____/_____/_____ Job Title _____ School/Department_____

Direct Supervisor _____Supervisor Work Phone (_____) _____

Employment Status: Full Time ☐ Part Time ☐ Date Injury Reported to Employer _____

INJURY OR EXPOSURE INFORMATION (To be filled out by the employee)

Date of Injury _____/_____/_____ Time of Injury ____:_____ Location Injury Occurred _____

Names of Witnesses _____

Describe Your Injury _____

Part Injured _____ Right Side ☐ Left Side ☐ Both ☐

How did the injury occur? (Be detailed and specific. If additional space is needed, please attach documentation to this form.)

_____

TREATMENT INFORMATION (REQUIRED, PLEASE CIRCLE)

Declined Treatment ie: (Band-Aid / Near Miss) First Aid Work Med Clinic. Emergency Room Other Clinic (please list) _____

***IF SENT TO A MEDICAL FACILITY, EMPLOYEE MUST BRING BACK A WORK STATUS FORM FROM THE PHYSICIAN'S OFFICE. IF THE PHYSICIAN HAS ORDERED WORK RESTRICTIONS, PLEASE CONTACT INSURANCE IMMEDIATELY.**

As an employee, I understand that if my pain increases or I decide to seek further medical treatment, I will call Tristar Risk Management at (801) 713-9140 (ext. 2211) beforehand. I also acknowledge that it is my responsibility to make sure I go to all my medical follow-ups, appointments, and follow physician recommendations. Finally, I acknowledge that I will **speak directly** to my supervisor ***and*** the Insurance Department at (801) 567-8070 if I am given restrictions by the treating physician or if I will be unable to work because of the injury.

_____ _____

Employee Signature **Date**

SUPERVISOR INVESTIGATION OF INJURY (Please fully answer all questions. Additional investigation may be required depending on severity of injury.)

Has this employee been injured on the job before? Yes No If yes, explain _____

Was the injury reported immediately after it occurred? Yes No If no, why? _____

Was equipment or apparatus involved in the injury? Yes No If yes (a) Did equipment appear to be used appropriately? Yes No

Specify Equipment _____ (b) Was there any apparent malfunction of the equipment? Yes No

Will additional safety measures/training need to be provided in the future? Yes No If so, what? _____

_____

Did you inspect the location/interview witnesses? Yes No If yes, please attach an explanation of your findings.

Is the employee's account of the incident accurate with the results of the investigation? Yes No

As a supervisor, I acknowledge that it is my responsibility to be informed about this employee's restrictions and how the employee is recovering. I also acknowledge that I will inform the Insurance Department at (801) 567-8070 immediately if the employee misses a day of work **AT ANY TIME** due to this injury. I also am aware that it is my responsibility to remain in contact with the employee if the employee is unable to return to work and document contacts made (phone log provided on reverse side of this form).

_____ _____

Supervisor Signature (if not Principal/Director) **Date**

_____ _____

Principal/Director Signature **Date**

Date Received in Insurance Services _____ No Action Meeting with Employee Training Other _____