KJUHSD

Employee Report Of Injury Or Illness

Return this form to your supervisor

Employee's name ____

Job Position/Title ____

Shift hours _________ Days off ___________ Supervisor's name ____________________

Date and time of injury or illness ________________ Location ______________________________

Task being performed when injury occurred ____

Date and time injury or illness reported ________________ To whom? ____________________

Name(s) of witness (es) ____

Describe how the injury or illness occurred:

What part of the body was affected?

Describe the injuries or illness in detail:

Date, time you first sought medical attention:

Name of doctor and/or hospital:

Could anything be done to prevent occurrences of this type? If so, what?

Signature of Employee

Date