ON THE JOB INJURY OR ILLNESS REPORT

Please Print:

Last Name _____ First Name _____ MI _____ Birth Date _____

Home Address _____ City _____ State _____ Zip _____ SS# _____

Phone Number _____ Gender: ☐ Male ☐ Female Marital Status _____

District and Job Title _____ _____

Do you have other regular employment outside of the School District? ☐ Yes ☐ No If Yes, complete the following:

Where is your other employment? _____

How many hours do you work per week? _____

What is your weekly wage? _____

Date of injury or initial diagnosis of occupational illness: _____ Time of injury: _____ ☐ A.M. ☐ P.M.

What time did your shift/work day start? _____ ☐ A.M. ☐ P.M.

Were you on the District premises? ☐ Yes ☐ No Where? Specify location: _____

Please describe what you were doing when you were injured. Tell how the injury occurred and what you were doing before the incident.

_____

Describe the injury or illness in detail. Be specific. Indicate the nature of the injury/illness and the part of the body affected. For Example: bruised left elbow, sprained right ankle.

_____

What tools, equipment, machines, objects or substances were involved?

_____

Co-Worker(s) who may have witnessed your injury: Name _____ Home Phone # _____

Did you go to a doctor? ☐ Yes ☐ No If YES, please provide the Doctor's name and address on the line below.

Date of initial visit to the doctor: _____ _____

Were you hospitalized? ☐ Yes ☐ No If YES, please provide the Hospital name and address on the line below.

_____

Did you lose time from work on the date of injury? ☐ Yes ☐ No If YES, indicate hours lost: _____

If No, but there was lost time later, indicate first date of lost time: _____ This could happen if you finished your workday on the date of injury, but the pain become more severe and you could not report for work the following day.

Estimated time loss for this injury: _____

If your Doctor says you cannot return to work for at least two weeks, indicate "minimum 2 weeks". Or, if you expect no lost time, indicate '"0". _____ This will not limit your benefits.

Please submit the "Report of Workability" from your doctor.

Name of supervisor who first received knowledge of your injury: _____ Title _____

Signature of Injured Employee _____ Date _____

Signature of Supervisor _____ Date _____

INSTRUCTIONS FOR COMPLETING THE ON THE JOB INJURY OR ILLNESS REPORT

Minnesota laws require that employers carry worker's compensation insurance coverage for employees. Any employee injured on the job or contracting an illness or disease as a result of their occupation must file a report immediately upon injury or initial diagnosis of occupational illness. It is important that the report is filed in a timely manner to assure eligibility for benefits under this insurance coverage. If you cannot complete the report yourself, someone must do it for you.

The Minnesota Occupational Safety and Health Act of 1973 also provides job safety and health protection for workers. The purpose of the law is to assure safe and healthful working conditions throughout the state. This law also requires that employer reports be made out and records be kept of each occupational injury or illness.

The form on the reverse side of this sheet covers all the information necessary to file the reports and keep the records required by law. PLEASE BE VERY DETAILED IN COMPLETING YOUR REPORT. Some items of information requested on this form may already be on record in another office in the district, but we ask that you fill out the form completely to help us expedite filing reports with our insurance carrier.

In addition to this form, you supervisor may submit a supervisor's report.

If you have any questions regarding this report, please call 218-327-5722.