Lansing School District

Human Resources

CLEAR FORM

SUBMIT FORM

Occupational Injury / Illness Incident Report

Building: _____ Date of Report: _____

EMPLOYEE INFORMATION (Please type all information)

Name: _____ ID #: _____

Home Address: _____
Street Address *City* *State* *ZIP*

Home Phone: _____ Sex: ☐ Female ☐ Male DOB: _____

Occupation: _____

INJURY/ILLNESS INFORMATION (Check One) ☐ Injury ☐ Illness ☐ Death

Address of Building: _____

Specific Location in Building of Injury: _____
(Ex: 3rd floor, Art Room #100)

Date of Injury / Illness: _____ Time of Day Injury / Illness Occurred: _____
(Ex: 10:35 AM)

Date Stopped Work: _____ Date Returned to Work: _____

What was employee doing when injured? (Be specific)

How did accident happen? (Give all details)

Describe Injury / Illness in detail (Indicate part of body affected)

Object / Equipment / Substance inflicting injury:

Did you seek treatment? ☐ Yes* (List below) ☐ No / Precautionary report only

*** Treatment required by an employer designated physician**

Hospital/Place of Treatment _____ Treating Physician: _____

Address: _____

Employee's Signature _____ Date _____

This section needs to be completed by a Supervisor

Supervisor's Comments

Condition of area where injury occurred (Ex: ice, snow, unleveled ground, etc.) _____

Was anyone notified if condition warrants and investigation or repair? **Yes** ☐ **No** ☐

Who was notified _____ Date notified _____

Signature of Supervisor _____ Date _____