550 Millard St.
Saginaw, MI 48607-1193

Office of Human Resources
FRINGE BENEFITS DIVISION

EMPLOYEE INJURY REPORT
for
Worker's Compensation

Report on this form all injuries, including diseases which arise out of and in the course of employment. **Report must be in the Fringe Benefits Office within 72 hours of the injury.**

INJURED EMPLOYEE:

Name ______________________________ Home Telephone ______________

Address ____
street city state zip code

Occupation ______________ Birth Date ____________ S/S # ______________

School/Building assigned ______________________ Marital Status ________ Sex _____

Place of Accident ______________________________ School ______________
(hallway, classroom, cafeteria, etc.)

On employer's premises? _____ Yes _____ No

INJURY or DISEASE:

Date & Time of Injury/Illness ______________ Last Day Worked ________ Est. Length of Disability ________

Description of Injury/Disease (part of body) ______________________________

What was employee doing when injured? ______________________________

How did it happen? ______________________________

____

____

Name of object or substance which directly injured employee ______________________________

____ Did employee die? _____

MISCELLANEOUS:

Attending Physician ______________ Address ______________________________

Hospital (if any) ______________ Address ______________________________

Were X-rays taken? ________ Witness to injury ______________________________

Treatment required (explain) ______________________________

REMARKS: What can be done to prevent re-occurrence? ______________________________

____

Signature of Employee ______________________________ Date ______________

Signature of Principal/Supervisor ______________________________ Date ______________

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