CAPE GIRARDEAU PUBLIC SCHOOLS
301 NORTH CLARK AVE • CAPE GIRARDEAU, MO 63701 • PHONE: 573-335-1867 • FAX 573-335-1820

Employee Injury Report Form

Instructions: Employees shall use this form to report all work related injuries and illnesses. This form shall be completed as soon as possible and given to the building nurse within 24 hours of the accident/ injury for further action.

Date:_____

Employee Information: **PLEASE PRINT**

SSN#_____-_____-_____ Name: _____

Phone: (Cell)_____(Home)_____(Work) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth:_____/_____/_____ Sex:_____Male_____Female

Marital Status: _____ Number of dependents: _____

Title:_____Status: Full/Part-time_____Wages: $_____

Occupation: _____ Date of Hire:_____/_____/_____

Injury Information:

How did injury occur: _____

Date of injury:_____/_____/_____ Time of accident: _____ Time work began: _____

Body part injured: _____

Description of injury: _____

Accident location: _____

Witness information: _____

Did the injury occur on employer premises?_____Yes _____No

If not, location of accident: _____

Does the employee need outside medical attention? Yes No

Transportation to medical attention: _____

Signature of injured employee: _____

Signature of nurse: _____

Signature of supervisor/building principal: _____

Additional comments: _____
