FOREST HILLS PUBLIC SCHOOLS
EMPLOYEE REPORT OF INJURY FORM

EMPLOYEE WORK INJURY REPORT **Fill All Blanks in Completely**

Employee Name_____ Social Security # _____

Address _____ Date of Birth _____
Street Number & Name City/State Zip Code MM/DD/YYYY

Primary Phone # _____ Work Phone # _____ Primary Email _____

Job Title_____ School/Building Assigned_____

Time Emp Began Work_____ ☐ AM ☐ PM Time Injury Occurred_____ ☐ AM ☐ PM

Date of Injury _____ Exact Place of Accident_____
MM/DD/YYYY

What were you doing just before the incident occurred? Describe the activity as well as the tools, equipment, or material you were was using. Be specific. *Examples: "climbing a ladder while carrying electrical materials"; "walking outside at the bus garage near the fueling station"; "lifting a box of books."*

_____

_____

_____

What was the exact injury or illness? What object or substance directly caused harm? Tell the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or "sore." *Examples: "strained back"; "fell on right hip"; "cut left hand."*

_____

_____

_____

Description of First Aid Rendered _____

Who Rendered First Aid? _____
(Name) (Phone Number)

Witness(es) to Accident _____
(Name & Phone Number) (Name & Phone Number)

Employee must go to Corewell Health URGENT CARE on the day of the injury. Do not seek treatment from a personal doctor. Attached is a list of approved locations and the authorization to treat form.

Did you seek medical treatment? ☐ Yes ☐ No If Yes, Date _____
MM/DD/YYYY

If Yes, did you go to an authorized Corewell Health Urgent Care? ☐ Yes ☐ No

_____ _____
Signature of Employee Date of Report

Completed form should be forwarded within 24 hours to the Human Resources Office
Confidential Fax: 616-493-8559
Email: jjewell@fhps.net

FOREST HILLS PUBLIC SCHOOLS
SUPERVISOR REPORT OF INJURY FORM

SUPERVISOR REPORT OF WORK INJURY

Was the employee performing his/her assigned work when injured? Yes No

Describe the work being performed at time of injury. Be specific. _____

_____

_____

What machines or equipment were involved? _____

_____

_____

Were any unsafe conditions present which caused this injury? _____

_____

_____

What will be done to prevent a repetition of this type of injury? _____

_____

_____

_____

Employee must go to Corewell Health Urgent Care. Do not seek treatment from a personal doctor or another clinic.

Did employee seek medical treatment? Yes No If Yes, Date _____
MM/DD/YYYY

If Yes, did employee go to an authorized Corewell Health Occupational Health Clinic, above? Yes No

_____ _____
Supervisor Signature Date of Report

_____
Supervisor Printed Name Phone Number Email

Completed form should be forwarded within 24 hours to the Human Resources Office
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Email: jjewell@fhps.net