FIRST REPORT OF INJURY

Date of Report: _____/_____/_____

Date Notified Employer: _____/_____/_____

Date of Injury: _____/_____/_____ Time of Injury: _____:_____ AM/PM (circle one)

EDUStaff Employee Information:

Employee Name (Last, First, Middle): _____

SSN: _____-_____-_____ DOB: _____/_____/_____ Sex: M/F (circle one)

Address (Number & Street): _____

City: _____ State: _____ Zip: _____

Phone Number: _____-_____-_____ **Hire Date:** _____/_____/_____

Job Title:_____

Injury Report Information:

Job Location: _____

DISTRICT: _____

Start Time: _____:_____ AM/PM (circle one) End Time: _____:_____ AM/PM (circle one)

Address (Number & Street): _____

City: _____ State: _____ Zip: _____

Witness to Injury: _____Witness Phone Number(s): _____-_____-_____

Explain How Injury Occurred: _____

_____

_____

Nature of Injury: _____

4120 Brockton Dr SE,
Suite 200
Grand Rapids, MI 49512

Phone: 877.974.6338
Fax: 877.974.6339
E-mail: info@edustaff.org

edustaff.org

Part of the body directly affected by the injury: _____

Last Day Worked: _____/_____/_____ Date Employee Returned: _____/_____/_____

Was the injury fatal? Yes/No (circle one) If yes, date of fatality: _____/_____/_____

Did employee seek medical treatment? Yes/No (circle one)

If yes, date of treatment: _____/_____/_____

Name of treatment facility: _____

Address (Number & Street): _____

City: _____ State: _____ Zip: _____

Restrictions: _____

_____

Expected return to work date: _____/_____/_____

District Information:

Building Supervisor: _____
(printed name and signature)

Phone Number: _____-_____-_____

Date: _____

Feedback:_____

_____

_____

_____

_____

Please return via email to EDUStaff HR at humanresources@edustaff.org or via fax to 877-974-6339.
Thanks!