EAGLE MOUNTAIN- SAGINAW
INDEPENDENT SCHOOL DISTRICT
EMPLOYEE'S REPORT OF ON-THE-JOB INJURY

(This form must be **completed in full detail and signed** by the injured employee **within 24 hours** of injury)

Personal Information	
Full Name (Last, First M.I.):	**Email Address:**
Your Address (number and street):	**City and Zip:**
Home Phone #:	**Work Phone #:**
Date of Birth (mm-dd-yy):*	**Sex: (please circle)*** **Male** **Female**
Job Title:	**Facility (Bldg.) or Dept. you work in:**
Years you have worked in current job:	**Years you have worked in the District:**

Details of Injury

Date of injury:_____Time of injury:_____a.m./p.m.

Building and specific location where injury occurred:_____

Has the incident been reported to your supervisor? (circle) YES or NO

When did you report? Date Reported:_____Time reported: _____a.m./p.m.

To whom? _____Date: _____Time reported:_____a.m./p.m.

Were you exposed to someone else's blood or body fluids? (circle) YES NO

If yes, did you follow the District's safety protocol? YES NO

Was appropriate footwear worn at the time of the injury? YES NO

Was safety equipment provided to you? If so, were you using it at the time of your injury?

Did your injury occur because of human or machine error? _____

In your opinion, what was the cause of the injury?

What safety measures do you think can be taken to prevent an injury of this type?

Did you seek medical treatment for your injury? (circle) YES NO

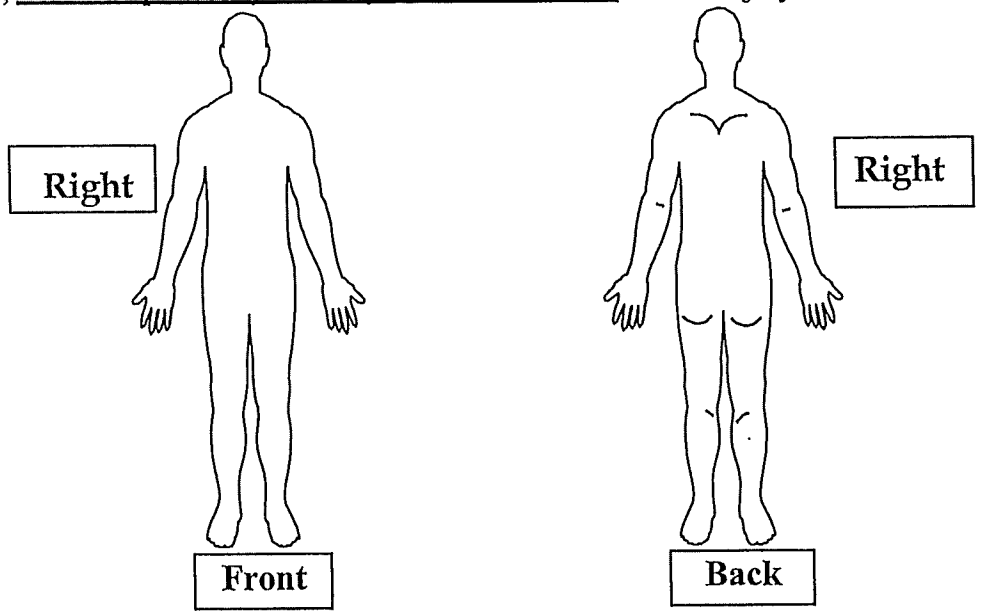
Name of doctor providing treatment:_____

Doctor's address and phone number:_____

How did your injury happen? (***DESCRIBE YOUR ACCIDENT IN DETAIL***):

On the diagram provided below, **circle the parts of your body and check the list** to show injury:

	Indicate R or L side, top or bottom, front or back:
Head	_____
Arm	_____
Hip	_____
Chest	_____
Shoulder	_____
Abdomen	_____
Leg	_____
Neck	_____
Finger	_____
Knee	_____
Ankle	_____
Foot	_____
Back	_____
Other	_____



Who were the witnesses to the incident causing your injury?

Was anyone else injured in this incident?

*This information is required by the State of Texas and Texas Workers' Compensation Commission.

I certify that the information contained in this report is true and correct.

I understand that any falsifications of information regarding an on-the-job injury may result in disciplinary action and/or prosecution under the appropriate State Criminal Statutes.

I hereby authorize the release of all medical records relating to the above noted incident to my employer, his agent, or insurance company.

Employee Signature_____ Date _____

Email completed report to Kimberly Heiskell, Coordinator of Risk Management: kheiskell@ems-isd.net