

**Davenport Community School District
EMPLOYEE FIRST REPORT OF INJURY FORM
For Workmen's Compensation Service and IOSAH**

If you wish to be treated after this form is submitted and reported to EMC/MEDCOR you must contact Jaime Kroeger in HR.

Name of injured employee: _____ SSN: _____ - _____ - _____
(first) (m.i.) (last)

Home Address: _____
(street) (City) (State) (Zip)

Home Ph: () Cell Ph: () DOB: / /

Sex: _____ Marital Status: _____ Total # Dependents: _____

Job Position: _____ Building(s): _____ Hours/Day: _____

Start / End Times: : am/pm - : am/pm Number of Days Worked/Week: _____

Was the place you were injured at the same as above: Y N Location in Building: _____
If not, what building were you at? _____

If not District property, please give the place and address of injury: _____
Did you notify someone there of the injury? Y N If so, who? _____

What specific job/duties were you performing when injured? _____

(Be specific. If you were using tools or equipment or handling material/s, name them and tell what you were doing with them.)

Was injury caused by a failure of injured employee to use or observe safety equipment or regulations? _____

Was injury caused by a student/s? Y N If yes, please list student name/s: _____

Date & time of Injury or initial diagnosis of occupational illness: / / : am/pm

Was employee disabled? Y N Date disability began: / /

When did you first notify your supervisor of the injury? / / Supervisor: _____

Describe the injury or illness in detail and indicate the part/s of the body affected: _____

(Examples: amputation of right index finger at second joint; fracture of ribs; bruise to left thigh; rash on both hands; scratch to left wrist)

Did employee require treatment by a doctor at the time of injury? Y N
Name & address of doctor consulted: _____

Did employee require treatment at a hospital at the time of injury? Y N
Name & address of hospital: _____

Name(s) & Phone No. of Witnesses: _____

Does injured employee hold second job? Y N Where? _____

Date of Report: / / Employee Signature: _____

Supervisor Signature: _____

**SCAN & EMAIL FORM IMMEDIATELY TO JAIME KROEGER, HUMAN RESOURCES,
OR FAX TO HR AT (563) 445-5988.
ALL EMPLOYEES MUST ALSO REPORT ANY INJURY TO THE EMC/MEDCOR REPORTING SYSTEM AT 844-322-4668**