

Canutillo ISD

Employee Incident Report

(MUST BE COMPLETED BY THE INJURED EMPLOYEE AND FORWARDED TO RISK MANAGEMENT SPECIALIST WITHIN 24 HOURS OF INCIDENT)
P.O. Box 100 Canutillo, Texas 79835 877-7428 office 217-9478 cell 877-7576 fax

Employee Name _____ Work Location _____

Employee Mailing Address _____ City _____ State _____ Zip _____

Home Phone # _____ SS# XXX-XX-_____ Male Female

Occupation _____ Date of Birth _____

Married Single Divorced Spouse's Name _____

Date of Injury _____ Time of Injury _____ AM PM Time Employee Began to Work _____ AM PM

Detail Description of Incident _____

Exact Location of Incident _____

Unsafe Act Contributing to the Incident _____

Was Safety Equipment Being Used? Yes No N/A

Specific Body Part Injured _____

List All Witnesses _____

Name of Supervisor _____ Date Supervisor was Notified _____

Nurse Assessment _____

Was examination or treatment refused? Yes No If yes, reason for refusal: _____

I have been notified that I must seek medical treatment with the District's Optimum Care Physicians which are Upper Valley urgent Care Center or Vinton Medical Center. Approved facility for emergency is Providence Memorial Hospital. Employee's initials denote knowledge of medical treatment procedures and acceptance responsibility. _____ Employee Initials

I hereby certify that the above statement is true and correct to the best of my knowledge. I understand that any falsification of information regarding an on the job injury may result in disciplinary action and/or prosecution under the appropriate State Criminal Statutes. I authorize any and all providers of medical or surgical treatment deemed necessary in regard to my reported occupational injury or illness to release any medical information acquired in the course of my treatment to my employer and representatives of Texas Association of School Board, Risk Management Fund.

Employee Signature _____ Date _____

Supervisor Signature _____ Date _____

Circle exact area of body injured

