Valley View School District 365U
EMPLOYEE'S REPORT OF INJURY

Information About You

Your Name: _____

Address: _____

Phone #: _____

Employer's Name: _____

Marital Status: S ☐ M ☐ D ☐ W ☐ Sex: M ☐ F ☐

Children under 18 (sex and age: _____

Height: _____ Weight: _____ Average Weekly Wage: _____

Length of Employment: _____ Days & Hours Worked: _____

Other Employment: _____

Information About Accident

Date of Accident: _____ Time: _____

Place of Accident: _____

_____

What were you doing before the accident? _____

_____

What happened? _____

_____

_____

Witnesses, if any: _____

_____

Who did you report the injury to? _____

_____

What date did you report it? _____

_____

Information About the Injury

What part of your body was injured? _____

Any other part or parts injured? _____

What kind of injury (strain, cut, broken bone)? _____

_____

Exact location of pain(s): _____

_____

Information About Treatment

What doctor is treating you (name, address, phone #)? _____

_____

Who is your family doctor? _____

What clinic is treating you? _____

What hospital is treating you? _____

What treatment are you getting (medication, physical therapy, rest, etc.)? _____

_____

Has the doctor told you to be off work? _____

_____

General Information

Have you ever injured the same part of your body before? _____

Explain: _____

Have you ever injured any other part of your body before? _____

Explain: _____

Do you have any serious illness (Diabetes, High Blood Pressure, etc.)? _____

Explain: _____

Have you understood the questions you have answered? _____

Signed: _____

Date: _____