RM0001
Rev. 9/04

EMPLOYEE REPORT OF INJURY OR OCCUPATIONAL DISEASE

Risk Management Department
Lincoln Public Schools

Complete ONLY if seeking medical attention or missed work due to injury
Fill in all blanks completely and submit to box 14 within 24 hours

First Name:_____ Middle:_____ Last Name:_____ SS#:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Gender:_____ Marital Status:_____ # of Children Under 18:_____

Occupation:_____ Special Education: ☐ Yes ☐ No

Building Where Employed:_____ Work Phone:_____ Date of Birth:_____

LPS Start Date:_____ Work Day Begins:_____ ☐ am ☐ pm Work Day Ends:_____ ☐ am ☐ pm

Date of Incident/Exposure/Diagnosis:_____ Time of Incident: _____ ☐ am ☐ pm

Describe Where Injury Occurred:_____
Ex: Building Address, Room Number, Vehicle Accident Location, Playground, etc.

Describe in Detail How
Incident/Exposure Occurred:

List All Body Parts Injured:
(ex. left foot, right arm, lower back)

1). Complete and Attach Physician Choice Form
2). Work Release Must Be Sent to Risk Management Within 24 Hours

Physician Name:_____ Date of Treatment:_____

Hospital Name:_____ Date of Treatment:_____

Sent Home? ☐ Yes ☐ No Dates of Absences Due To Incident/Exposure:_____

Incident Witness? ☐ Yes ☐ No Witness Name:_____

I CERTIFY THAT THIS INFORMATION IS TRUE AND CORRECT

_____ _____
Employee Signature *Date Signed*

_____ _____
Nurse/Health Technician Signature *Date Signed*

_____ _____
Supervisor/Principal Signature *Date Signed*