# East Millinocket School Department

## EMPLOYEE INCIDENT REPORT

**This report is REQUIRED even though you may have reported this injury to your Supervisor**.

Name _____

Address _____ Phone _____

SS# _____ Gender _____ Date of Birth _____Date of Hire_____#Dependents _____

Employee Email Address _____Secondary Email_____

Employer/School_____Supervisor_____

***Do you work for another employer***? Name/address of that Employer_____

Occupation when injured _____ Secondary Employment _____

Were you doing your regular work? _____ If not, what work? _____

Date of injury _____ Hour of day _____ AM ____ PM **What time did you begin work: _____**

Exact place where injury occurred _____

Describe fully how injury occurred:_____

_____

Describe your injury in detail (mention body parts affected) **(specify (L) or (R) side)** _____

_____

_____

Do you have any pre-existing or contributory Injuries/Conditions? _____

_____

Names of any witnesses _____

_____

Name of doctor treating you ***for this injury*** _____ First Date seen: _____

Doctor's Address _____

Name and addresses of medical providers seen ***for this injury***_____

_____

Did you lose time from work? _____ If so, when did disability start?_____

Have you returned to work? _____ When? _____

Light Duty _____ Regular Duty _____ Number of Hours _____ Rate of Pay $_____

To whom was injury reported? _____When (date)?_____ AM ____ PM _____

_____ _____

Date Signature

Please return this form to the Central Office.