VCSC FIRST REPORT OF EMPLOYEE INJURY/ILLNESS

PLEASE TYPE or PRINT IN INK

EMPLOYEE INFORMATION						
Social Security Number:	Date of Birth:	Sex: ☐ Male ☐ Female ☐ Unknown		Occupation/Job Title and Employer: (VCSC, CBSED, Kelly Services)		
Name:		Marital Status: ☐ Unmarried ☐ Married ☐ Separated ☐ Unknown		Building You Are Assigned to:		
Address:				Full-time	Part-time	VCSC Emp #: ☐ I want medical treatment. ☐ I decline medical treatment.
Telephone Number: (include area code)				**Note:** You have the right to receive medical treatment at no cost to you. If you choose to receive medical treatment you must obtain care from an authorized occupational health center.		

INCIDENT / TREATMENT INFORMATION - YOU MUST PROVIDE FULL DETAILS AND COMPLETE ALL SECTIONS			
Date of Incident:	Time of Incident: ☐ AM ☐ PM ☐ Cannot Be Determined	Date Employer Notified:	Type of Incident: (injury or illness)
Date of Hire:	Time Workday Began:	Type of Injury/Illness: (e.g., left ankle, right arm, asthma)	
Injury/Illness occurred on employer's premises? ☐ Yes ☐ No		If not on employer's premises, provide details:	
Department or location where incident occurred: (e.g., classroom (include #), cafeteria, playground, gymnasium, bus (include #), restroom, parking lot, hallway)		All equipment, materials, or chemicals involved in incident:	
Specific activity engaged in during incident:		Work process employee engaged in during incident:	
Describe the nature of the incident and how it occurred, include as much detail as possible:			
Initial Treatment:			

Name of witness #1:	Telephone number:	Address:	INITIAL TREATMENT ☐ No Medical Treatment ☐ Minor: By Employer ☐ Minor: THRH Occ Med ☐ ER / Urgent Care ☐ Ambulance Called ☐ Hospitalized > 24 Hours
Name of witness #2:	Telephone number:	Address:	
Date Prepared:	Name and Title of Preparer:	Telephone Number:	

Employee Signature: _____ **Date:** _____

WITHIN 24 HOURS, COMPLETED FORM MUST BE EMAILED TO THE FOLLOWING:
brandi.woelfle@vigoschools.org AND jani.cundiff@vigoschools.org

TO BE COMPLETED BY RISK MANAGEMENT:
CLAIM NUMBER: OSHA RECORDABLE: Y N DATE ADDED: