Insurance Office – white
Supervisor – yellow
Injured Employee – pink

KENTWOOD PUBLIC SCHOOLS
5820 Eastern Avenue SE
Kentwood, Michigan 49508

EMPLOYEE REPORT OF WORK-RELATED INJURY

EMPLOYEE NAME (First, Middle Initial, Last) _____

ADDRESS _____ ZIP _____

TELEPHONE NUMBER _____ SOCIAL SECURITY # _____

OCCUPATION OF INJURED EMPLOYEE _____

EMPLOYMENT STATUS: FULL TIME_____ PART TIME_____ OTHER_____

DATE OF BIRTH _____ SEX M ____ F____ MARITAL STATUS_____

Please List All Dependents

Name of Dependent	Age	Name of Dependent	Age

DATE OF INJURY _____ TIME OF INJURY _____ AM____ PM_____

LAST DAY WORKED_____ RETURN TO WORK DATE _____

PLACE OF INJURY (Building/Location) _____

WITNESSES' NAME _____

PART OF BODY INJURED _____

DESCRIBE HOW ACCIDENT OR INJURY OCCURRED _____

_____

_____

NAME AND ADDRESS OF HOSPITAL/CLINIC WHERE TREATED _____

_____

TO WHOM WAS INJURY REPORTED _____

ON WHAT DATE_____ AT WHAT TIME _____ AM____ PM_____

HOW CAN THIS TYPE OF INJURY BE PREVENTED IN THE FUTURE?_____

_____

_____ _____

Signature of Injured Employee Date

_____ _____

Signature of Supervisor Date

NOTE: Send to Kentwood Personnel Office within 24 hours of accident/injury.