

# ANTELOPE VALLEY UNION HIGH SCHOOL DISTRICT

## EMPLOYEE'S REPORT OF INJURY

---

NAME \_\_\_\_\_ SS# \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

POSITION \_\_\_\_\_ DATE OF HIRE \_\_\_\_\_

DAYS PER WEEK \_\_\_\_\_ HOURS PER WEEK \_\_\_\_\_

CONTRACT MONTHS \_\_\_\_\_ SITE \_\_\_\_\_

DATE OF INJURY \_\_\_\_\_ TIME OF INJURY \_\_\_\_\_ AM \_\_\_\_\_ PM

PART (S) OF BODY AFFECTED \_\_\_\_\_

WHAT EMPLOYEE WAS DOING WHEN INJURED \_\_\_\_\_

---

DESCRIBE ACCIDENT OR INJURY (PLEASE CONTINUE ON BACK OF FORM OR ATTACHED A SEPARATE  
PIECE OF PAPER IF NEEDED)

---

EQUIPMENT BEING USED \_\_\_\_\_

WITNESSES \_\_\_\_\_

DATE REPORTED TO SUPERVISOR \_\_\_\_\_

DATE REPORTED TO RISK MANAGEMENT \_\_\_\_\_

PREDESIGNATED \_\_\_ Y \_\_\_ N If yes, NAME OF PHYSICIAN \_\_\_\_\_

ADDRESS AND PHONE NUMBER OF PHYSICIAN \_\_\_\_\_

---

FIRST AID ONLY\* \_\_\_ Y \_\_\_ N

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

\*If medical care is not needed, this report will be kept on file as a first aid injury in case medical care is needed at a later date.