



ENGAGE. EMPOWER. EDUCATE.

First Report of Injury and Accident Investigation Form

Complete electronically immediately and email to
workcomp@mccsc.edu

Employee Information

Employee Name (First, Middle, Last)	School/Building
Job Title	Work Schedule (Days; Start Time; End Time)

Incident Details

Date of Injury	Time of Injury	Date Injury Reported	Location of Accident
Describe specific activities or work processes involved in during injury or illness:			
Describe how injury or illness occurred:			
List All Witnesses and Witness Comments:			

Employee Interview

What does employee state caused the accident:
What does employee suggest be done to prevent future accidents:
Body Part(s) Injured:
Type of Injury: (Sprain, Strain, Laceration, Cut, Bruise, Contusion, Repetitive Motion, Burn, Student Inflicted)

Medical Treatment

No Medical Treatment	Minor by Employer (Nurse/Health Aide)	Minor by IU Health Urgent Care	Emergency Room	Hospitalized
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Administrator Certification

Date of Report	Name of Reporting Supervisor	Title of Reporting Supervisor
Supervisor Description of What Happened		
Supervisor Analysis: (Adequacy of Supervision, Use of Protective Equipment, Condition of Tools/Equipment, Procedures/Work Rules, Training Needed, Unsafe Acts/Human Error, Safety Devices/Guards, Unsafe Conditions)		
Name of Administrator Completing Form		Title of Administrator