Crookston Public Schools
402 Fisher Ave., Suite 593
Crookston, MN 56716-2811

EMPLOYEE INCIDENT REPORT

Note: Please complete this form and return it to your supervisor immediately.

Employee Name (last, first, middle): _____

Employee Home Address: _____

City, State & Zip Code _____

Social Security Number: _____ Date of Birth: _____

Phone Number: _____ How long employed? _____

Department: _____ Job Title: _____

Supervisor: _____ Who did you notify of this incident? _____

Date of Incident: _____ Time of Day: _____am/pm Day Occurred: S M T W TH F S

Location of Incident: _____

Describe exactly what happened & how the incident occurred. Include details pertaining to equipment, environment, work location, work tasks, etc.: _____

_____

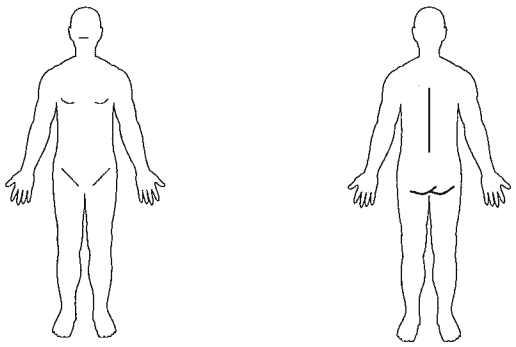
_____

_____

_____

_____

Indicate on the Diagram the location of your injury(ies):



Was first aid administered? Yes No When? _____ By whom? _____

Did you go to the Hospital? Yes No When? _____ Where? _____

Did you go to the Clinic? Yes No When? _____ Where? _____

Did you see a physician, chiropractor, nurse practitioner or seek other medical attention? ☐ Yes ☐ No

When? _____ Who? _____ Where? _____

Do you intend to seek additional medical care for this injury? ☐ Yes ☐ No

Who witnessed the incident? _____

How much time did you miss because of this incident? _____ When? _____

What actions do you intend to take to avoid this in the future? _____

_____

Do you have other regular employment? ☐ Yes ☐ No Where? _____

Employee's Signature: _____ Date: _____

ANY PERSON WHO, WITH THE INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION3, MNWC STATE STATUTE 60A.955.