

St. Francis Area Schools

Human Resources
4115 Ambassador Boulevard NW, St. Francis, MN 55070
763-753-7040 • www.isd15.org

First Report of Injury

*The employee's supervisor needs to fill this First Report of Injury out within 24-hours of the incident.
Send completed form to Joyce Froh, joyce.froh@isd15.org.*

Employee Information

Name _____ Employee ID _____ Birthdate _____ Sex M F

Home phone _____ Cell phone _____ Work phone _____

Address/City/Zip _____

Hours per day worked _____ Hours per week _____ Occupation _____ Site _____

Information About The Injury

Date of claimed injury _____ Time work begins _____ AM PM Time of injury _____ AM PM

Date incident reported to employer _____ Date form was filled out _____

Did injury occur on employer's premises? Yes No If no, where? _____

What was the employee doing just before incident occurred?

What happened? **Be specific.**

What is the injury or illness? Tell us the part of body affected and how it was affected. **Be specific.**

What object or substance directly harmed the employee? Examples, concrete floor, chemical, etc.
(If this question, does not apply—please mark—N/A)

What medical treatment was administered in the health office?

Witness(s) _____ Phone _____

Comments

Supervisor informed? Yes No Name _____ Date _____

Supervisor Signature _____ Date _____ Phone _____