EMPLOYEE INJURY REPORT

Bloomer Elementary School

NAME: _____

ASSIGNMENT: _____ DATE of INJURY: _____

TIME OF INCIDENT: _____

LOCATION OF INCIDENT: _____

DESCRIPTION OF INJURY

_____

WITNESS: _____

PHYSICIAN'S SERVICE NEEDED:
(If so, please indicate Physician's name and description of treatment)

Signature: _____ Date: _____

Submit this form to the District Office within 24 hours of the injury.