Huron Intermediate School District Policy # 32000
EMPLOYEE INJURY REPORT – FORM 2B

EMPLOYEE INFORMATION

Employee name _____ Birth date _____

Address _____ Phone # _____

Job position _____ Was employee on duty? ☐ Yes ☐ No SS#:_____

INJURY DETAILS

Date of injury: _____ Time: _____ ☐ a.m. ☐ p.m.

Occurred at: ☐ Huron Technical Center ☐ Huron Learning Center ☐ HISD office ☐ Transition building
☐ PREP building ☐ Storage shed ☐ Other _____

Place of injury:
- ☐ Classroom
- ☐ Gymnasium
- ☐ Hallway
- ☐ Parking lot
- ☐ Bathroom
- ☐ Sidewalk
- ☐ Cafeteria
- ☐ Playground
- ☐ Athletic field
- ☐ Other _____

Nature of injury:
- ☐ Scratch
- ☐ Head injury
- ☐ Fracture
- ☐ Sprain/strain
- ☐ Bruise
- ☐ Cut/puncture
- ☐ Burn
- ☐ Bite
- ☐ Dislocation
- ☐ Blood exposure*
- ☐ Other _____

*if blood exp, complete exposure worksheet

Body part injured:
- ☐ Left
- ☐ Right
- ☐ Ankle
- ☐ Foot
- ☐ Leg
- ☐ Arm
- ☐ Face
- ☐ Nose
- ☐ Back
- ☐ Finger
- ☐ Teeth
- ☐ Neck
- ☐ Hand
- ☐ Wrist
- ☐ Eye
- ☐ Knee
- ☐ Shoulder
- ☐ Other _____

How did the injury occur? (List basic facts chronologically. Use back of form if needed.)

Describe any conditions that appeared to contribute to the injury or exposure (i.e. wet floor, horseplay, etc.)

What safety devices were/were not in use?

List names of witnesses:
Name_____ Phone_____ Name_____ Phone_____

MEDICAL INFORMATION

Was on-site first aid administered? ☐ Yes ☐ No If yes, describe first aid: _____

Did you seek medical attention? ☐ Yes ☐ No Date medical attention was sought: _____

Name of treating physician _____ Medical facility _____

Return to work:
- ☐ Returned to work with no restrictions
- ☐ Returned to work with these restrictions: _____
- ☐ Sent home, to have physician recheck on: _____
- ☐ Hospitalized

I have provided this information as fact to the best of my knowledge. I also acknowledge that if I did not seek medical attention, I did have the opportunity to do so and I waive medical care at this time.

_____ _____ _____
Employee signature or Report prepared by | Title | Date

Supervisor Reviewed (Initial & Date) _____ Office use only: Claim #_____ Date entered:_____

Revised 8/2019