HAMILTON COUNTY DEPARTMENT OF EDUCATION
FIRST REPORT OF OCCUPATIONAL INJURY

THIS FORM MUST BE, IF COMPLETED, PRINTED AND SIGNED AND EMAILED TO: onjobinjuries@hcde.org ON DATE REPORTED

Clear

Incident Location (Facility, Department, or School)			Name: (First, Middle, Last)		
Street Address			Street Address		
City, State & Zip			City, State & Zip		
Department Division			Social Security Number	Email	
Date & Time Occurred	Work Phone #		Home Phone #	Date Hired	
First Aid Provider	Seeking Treatment? ☐ Yes ☐ No If yes, complete both TAF & RX Forms	Date of Birth	Gender ☐ M ☐ F	On Duty ☐ Yes ☐ No	Married ☐ Yes ☐ No
Initial Medical Provider	Treatment Date	Occupation	Hrs Worked Per Week	Yrs On Job	Shift Began
Describe clearly how the incident occurred. Include specific activity being performed and what directly harmed employee. (object, substance, other)					
Was Personal Protective Equipment Required? ☐ Yes ☐ No			In Use? ☐ Yes ☐ No		
If Personal Protective Equipment was required but not used, why not?					
Witness # 1 Home Phone # Work Phone #			Witness # 1 Home Phone # Work Phone #		
Describe the injury in detail and indicate the part of the body affected: (i.e. bruised, abrasion, sprain) and location (i.e. foot, right hand)					
What acts, failures to act, and/or workplace conditions contributed most directly to this incident?			Was the employee able to work the next scheduled work day after the date of the injury? ☐ Yes ☐ No If no, what was the last day worked?		
Corrective actions to prevent recurrence: Target Completion Date:			Has the employee returned to work? ☐ Yes ☐ No If yes, give date:		
Employee Signature: Date:			Did the employee die? ☐ Yes ☐ No If yes, give date:		
Supervisor Name: Supervisor Signature: Date:					