BIRDVILLE INDEPENDENT SCHOOL DISTRICT

EMPLOYEE'S REPORT OF ON-THE-JOB INJURY

(This form must be **completed in full detail and signed** by the injured employee **within 24 hours** of injury)

Personal Information

Your Full Name (Last, First M.I.):	**Social Security Number:**	
Your Address (number and street):	**City and Zip:**	
Home Phone #:	**Work Phone #:**	
Date of Birth (mm-dd-yy):*	**Sex: (please circle)*** **Male** **Female**	
Marital Status: (circle one): **Single Married Divorced Widowed Separated**	**Spouse's Name:***	**No. of Dependent Children:**
Job Title:	**Facility (Bldg.) or Dept. you work in:**	
Years you have worked in current job:	**Years you have worked in the District:**	

Details Of Injury

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

Building where injury occurred: _____ Exact location within building: _____

Has the incident been reported to your supervisor? (circle) YES or NO

When did you report? Date Reported: _____ Time reported: _____ a.m./p.m.

Have you reported your injury to BISD'S Workers' Compensation Office? (Extension #5855) YES NO

When did you report? Date: _____ Time reported: _____ a.m./p.m.

Were you exposed to someone else's blood or body fluids? (circle) YES NO

If yes, did you follow the District's safety protocol? YES NO

Was safety equipment provided to you? If so, were you using it at the time of your injury?

Did your injury occur because of human or machine error? _____

In your opinion, what was the cause of the injury?

What safety measures do you think can be taken to prevent an injury of this type?

Did you seek medical treatment for your injury? (circle) YES NO

(PLEASE COMPLETE OTHER SIDE AND SIGN)

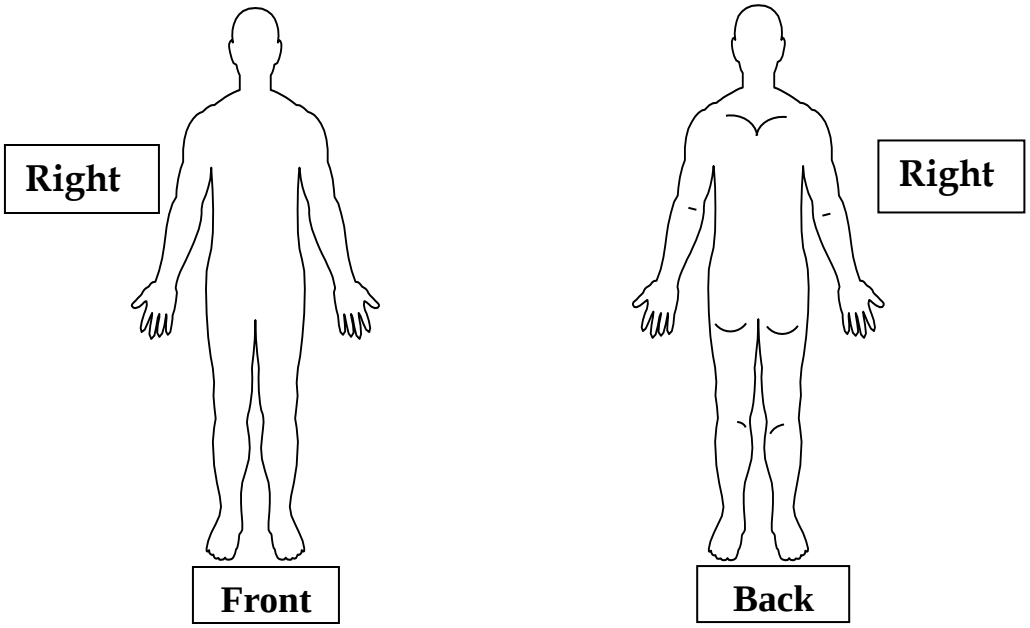
Name of doctor providing treatment: _____

Doctor's address & phone number: _____

How did your injury happen? (DESCRIBE YOUR ACCIDENT IN DETAIL):

On the diagram provided below, **circle the parts of your body and check the list** to show injury:

	Indicate R or L, top or bottom, front or back:
Head	
Arm	
Hip	
Chest	
Shoulder	
Abdomen	
Leg	
Neck	
Finger	
Knee	
Ankle	
Foot	
Back	
Other	



Who were the witnesses to the incident causing your injury?

Was anyone else injured in this incident?

*This information is required by the State of Texas and Texas Workers' Compensation Commission.

I certify that the information contained in this report is true and correct.

I understand that any falsifications of information regarding an on-the-job injury may result in disciplinary action and/or prosecution under the appropriate State Criminal Statutes.

I hereby authorize the release of all medical records relating to the above noted incident to my employer, his agent or insurance company.

Employee Signature _____ Date _____

Please fax and interoffice this form to the BIRDVILLE WORKERS' COMP OFFICE Fax: (817) 547-5533