Aurora Public Schools
Risk Management Department
(303) 365-7816
Fax (303) 326-1921

FIRST REPORT OF INJURY

This report should be completed by the employee and the Supervisor/Principal after an on-the-job injury and faxed to the above fax number **within 24 hours**. **Please complete ALL INFORMATION AS IT IS REQUIRED by Colorado Statute. Please see a school nurse, if possible, for initial treatment.**

SECTION 1: TO BE COMPLETED BY EMPLOYEE

Employee Name (Print Name Legibly)				Social Security Number	
Street/Home Address			City	State	ZIP
Date of Birth	Sex	Personal Phone Number	Marital Status	Personal Email	
Job Title		Department or School		Length of Experience at this Assignment	
Normal Work Hours (From – To)	Hours per Day	Days per Week	Job Assigned when Injured		

Information Concerning Accident

Hours Worked on the Date of Injury (From – To)	Date	Time	Location: Cafeteria ☐ Playground ☐ Hallway ☐ Parking Lot ☐ Gymnasium ☐ Classroom ☐ Other: _____

Accident reported to Supervisor/Principal: Date_____ Time_____	Were you able to continue work: Yes ☐ No ☐	If no, last day worked:	Date Returned to Work or Estimated Date of Return:

Have you been injured on the job before? Yes ☐ No ☐	Did this accident aggravate a previous injury/medical condition? Yes ☐ No ☐ If yes, explain and list name of physician:

Do you currently hold a second job? Yes ☐ No ☐ What is your title and duties? _____

What is your wage for the second position? _____ What are the average hours per week worked at the second job? _____

State part of body injured (indicate left, right, shoulder, foot, etc.) _____

IN DETAIL relate in your own words how injury occurred (i.e., task being performed, equipment used, special circumstance or condition, etc.)

_____

_____

_____

Do you feel you need medical attention? Yes ☐ No ☐ If no, please initial and date:	Witnesses:

I understand that I must be seen by One of the Four Designated Medical Providers for Aurora Public Schools. I further understand the list of designated medical providers is available from my school nurse, site secretary, the Risk Management Office and the Risk Management internal website.

It is unlawful to provide, false, incomplete, or misleading facts or information to an employer/insurance company for the purpose of defrauding or attempting to defraud the company. False statements could result in legal action (misdemeanor/felony), including imprisonment, fines, denial of insurance, civil damages and employment disciplinary action.

_____ _____

Signature of Employee Date

Employee Name _____

SECTION 2: TO BE COMPLETED BY NURSE, IF APPLICABLE

Please see the school nurse. Risk Management procedures include seeing a school nurse to triage the injury before seeking outside medical care. If you are unable to see the nurse, please call Risk Management at (303) 365-7816.

Nurse's Notes/Recommendations:

_____

_____

_____

_____

_____ _____

Signature of Nurse Date

SECTION 3: TO BE COMPLETED BY SUPERVISOR/PRINCIPAL

Was employee able to continue working? Yes☐ No☐ What was employee doing at time of injury?

Is this activity within their normal scope? Yes☐ No☐ If no, please explain:

Injury occurred because of: Intoxication☐ Safety Violation☐ Failure to use District Provided Personal Protective Equipment☐
Failed to Follow Procedure☐ Other☐

Was this injury preventable? Yes☐ No☐
What action will be taken to prevent a re-occurrence?

_____ _____

Printed Name of Supervisor/Principal Date

_____

Signature of Supervisor/Principal