New Milford Public Schools
Employee's First Report of Injury Form

Employee Name ______________________ SS # ________________________
ADDRESS: ______________________ DOB: ________________________
______________________ DOH: ________________________
______________________ TEL: ________________________
POSITION: ______________________

Date of Injury (Illness):______________________ Time Began Work :______________
Date Incident Reported to Supervisor:__________ Time of Injury: ______________

Location (Check one): ☐ NMHS ☐ SMS ☐ SNIS ☐ JPS ☐ NES ☐ HPS ☐ CO

Location Address: ____
Location Phone#: ____
Exact location @ facility (Rm # , etc.) :___________________________

Nature of Injury: (Illness, laceration, etc.)
____
____
____

Description of Incident (What was employee doing immediately prior to incident & what happened?):____
____
____
____

Name of Witness(es): ____

Contributing Factors (Unsafe condition, etc.) ___________________________________
____

Medical Treatment
None @ Present _____ Hospital: ER______ Admit_____
First Aid by Nurse _____ Physician____________________
First Aid by Other _____

Lost Time From Work: _____Yes _____No

The Business Office must be notified of all work related injuries.
The Business Office must be notified if this will result in lost time from work.

Supervisor's Name: ______________________________

Supervisor's Signature____________________ E-Signed:___ Date:_____________

Insurance office use only:

Ins. Carrier Notified: _______Claim # :______________ Date:_____________