PDRMA
PARK DISTRICT RISK MANAGEMENT AGENCY

Employee Injury Report

Form 04

1 Complete an Employee Injury Report for each employee injured.

2 Agency name | Today's date

3 Date of incident (mm/dd/yyyy) | Time of incident (hh/mm a.m./p.m.)

4 Name of person completing report | Title of person completing report

5 Business phone | Business email

6 How did the incident occur? (Provide a one-line factual description.)

7 Name of the location (park, pool, community center; *Ex. Smith Pool, Johnson Community Center*) or nearest intersection where the incident occurred.

8 Is there an address for this location? If yes, please provide the following:

Street address

City | State | Zip code

9 Location (Specify the exact type of location/facility where injury occurred. *Ex. maintenance garage, sports field, aquatic outdoor, golf course, etc.*)

10 Primary location (Specify exact location. *Ex. lap pool, cart storage, classroom, pavilion)*

11 Employer's FEIN

12 Did the employee miss more than three (3) scheduled workdays? ☐ Yes ☐ No ☐ Unknown

13 What was the employee doing when the accident occurred?

14 How did the incident occur? (Provide a detailed factual description.)

15 Employee last name | First name

Address

City | State | Zip code

Home phone # | Work phone # | Cell phone #

Best number to contact employee | Email

Social security number | Date of birth (mm/dd/yyyy) | Gender ☐ Male ☐ Female

Marital status (divorced/married/single/unknown) | Number of dependents | Does employee speak English? ☐ Yes ☐ No

Average weekly wage | Job title/occupation

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Form 04 (pg. 2)

15 What is the employee's employment status?

☐ Permanent full-time ☐ Permanent part-time ☐ Seasonal ☐ Intern ☐ Other

Date hired (mm/dd/yyyy)

What is the employee's tenure? (length of employment)

☐ Less than 1 yr. ☐ 1-3 yrs. ☐ 4-10 yrs. ☐ 11-19 yrs. ☐ More than 20 yrs.

Time employee began work on day of incident (hh/mm a.m./p.m.)

Last date employee worked prior to date of incident (mm/dd/yyyy)

If the employee died as a result of the accident, give the date of death. (mm/dd/yyyy)

Did the incident occur on agency premises? ☐ Yes ☐ No ☐ Unknown

Injury or illness? ☐ Injury ☐ Illness

Describe the injury or illness (affected body part and type of injury; ***Ex. contusion, bruise, laceration, sprain, break, etc.***)

What object or substance, if any, directly harmed the employee?

16 Did the injured employee seek medical attention? ☐ Yes ☐ No ☐ Unknown

17 If yes, was the treatment given away from the worksite? ☐ Yes ☐ No ☐ Unknown

18 Was the employee treated in an emergency room? ☐ Yes ☐ No ☐ Unknown

19 Was the employee hospitalized overnight as an inpatient? ☐ Yes ☐ No ☐ Unknown

20 Name of treating physician, health care provider, or emergency room

Address

City State Zip code Phone number