School District of Lodi

Student/Employee School Work Related Incident Report

**Directions: Please fill out the following form and send it to payroll at the Lodi School District Office*

Name:		*Grade/Job Title:*	

Date of Injury:		Time of Injury:		◯ AM ◯ PM

Location of Injury:		Name of Witness:	

Description: In your own words, explain in detail what you were doing immediately before the accident, and how the accident happened:

What part of the body was affected (be specific):			
Did you complete your work day? (Yes or No)	◯ Yes ◯ No		
Do you anticipate missing any work/school days due to this injury?			
Did you see a physician (yes or no)?	◯ Yes ◯ No	Date seen:	
Name of Physician:		Do you expect to see a physician for further medical need (yes or no)?	◯ Yes ◯ No
What could have been done to prevent this type of injury?			
Did you notify your immediate supervisor? (Yes/No)	◯ Yes ◯ No	*Date of Notification:*	

Note: If you have seen a Physician, please obtain the **Attending Physician's Return to Work/School Recommendations Record form** for the Physician to complete.

I hereby certify the above is true and correct to the best of my knowledge

Signature:		Date:	