



Ogden Preparatory Academy First Report of Injury Form

Employment Information

Name (First Middle Last)		Address (including zip)	
Date of Birth:		Social Security Number:	
Employment Start Date:		Gender:	
First Language:		Need Interpreter? (<i>circle one</i>) YES NO	
Job Title:			
Number of days worked/week:		Wage type (circle one): HOURLY SALARY	
Average hours worked/day:		Wage: \$	

Incident Information

Date of Injury:		Body part affected:	
Time of Injury:		Location:	
All equipment, materials or chemicals employee was using at time of accident/incident:			
How injury/illness/accident/incident occurred. Describe the sequence of events and include objects or substances directly involved in the incident. Include the work process the employee was engaged in at time of incident.			
Did employee miss work? YES NO If yes, how much time was missed?			
Were safeguards or safety equipment provided? YES NO If yes, were they used? YES NO			
Initial treatment: <input type="checkbox"/> NONE <input type="checkbox"/> First Aid at location <input type="checkbox"/> WorkMed <input type="checkbox"/> Other:			
Witnesses (name and phone number):			

Employee Signature:

Supervisor Name:		Date/time Supervisor was notified:	
Date/time Administration was notified:	Administrator notified (signature):		Name of person completing this form: