

Mansfield City Schools
P.O. Box 1448
Mansfield, OH 44901
(419) 525-6400 ext 56422

Injury/Illness Investigation

To be completed by employee (Complete within 24 hours or as soon as medically possible following incident and submit to Supervisor):

Name (first, middle, and last): _____

Home address (incl. city, state, zip): _____

Social Security #: _____ Sex: Male Female Age: _____

Date and time of injury/illness: _____ Date and time reported: _____

Building: _____ Department: _____ Title: _____

Description of injury/illness (who, what, when, where): _____

Nature of injury (ex: scratch): _____

Part of body (ex: right index finger): _____

Was medical treatment sought? Yes No If so, where: _____

Recommended corrective action: _____

Names and departments of any witnesses: _____

Employee's signature: _____ Date: _____

To be completed by Building Principal *(Complete immediately following accident and return to Safety & Health Coordinator within 24 hours of accident)*

Supervisor name: _____ Department: _____ Title: _____

Injury Illness Property damage Near Miss First Aid Death

Date and time of injury/illness: _____ Date and time reported: _____

Description of injury/illness (who, what, when, where): _____

Nature of injury (ex: scratch): _____

Was medical treatment sought? Yes No If so, where: _____

Part of body (ex: right index finger): _____

Recommended corrective action: _____

Supervisor's signature: _____ Date: _____

To be completed by School Nurse (if applicable):

First Aid provided: _____

By whom? _____ Date: _____

Comments: _____

School Nurse signature: _____ Date: _____

To be completed by Safety and Health Coordinator:

Medical treatment sought: _____

Was drug screen administered? [] Yes [] No Is incident recordable? [] Yes [] No

Was FROI filed? [] Yes [] No If so, date and time: _____

Corrective action taken: _____

Corrective action taken by whom? _____ Date taken: _____

Comments: _____

Safety and Health Coordinator signature: _____ Date: _____