RM0001
Rev. 8/19

EMPLOYEE REPORT OF INJURY OR OCCUPATIONAL DISEASE

Risk Management Department
Lincoln Public Schools

Phone: 402-436-1760
Fax: 402-458-3276

Employee must complete ONLY if seeking medical attention or missed work due to injury.
Fill in all blanks completely and submit to box 14 within 48 hours

First Name: _____ Middle: _____ Last Name: _____ Employee ID: _ _ _ _ _ _ _ _ _

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Gender: _____ Marital Status: _____ # of Children Under 18: _____

LPS Email: _____

Occupation: _____ Special Education: ❑ Yes ❑ No

Building Where Employed: _____ Work Phone: _____ Date of Birth: _____

LPS Start Date: _____ Work Day Begins: _____ ❑ a.m. ❑ p.m. Work Day Ends: _____ ❑ a.m. ❑ p.m.

Date of Incident/Exposure/Diagnosis: _____ Time of Incident: _____ ❑ a.m. ❑ p.m.

Did injury involve a student?: ❑ Yes ❑ No Student ID#/Name: _____ Special Ed. Student: ❑ Yes ❑ No

Describe Where Injury Occurred: _____
Ex: Building Address, Room Number, Vehicle Accident Location, Playground, etc.

Describe in Detail How Incident/Exposure Occurred:

List All Body Parts Injured *(ex. left foot, right arm, lower back)*:

1) Complete and Attach Physician Choice Form
2) Work Release Must Be Sent to Risk Management Before Returning to Work
3) Contact Risk Management prior to seeking treatment unless emergency

Physician Name: _____ Date of Treatment: _____

Hospital Name: _____ Date of Treatment: _____

Sent Home?: ❑ Yes ❑ No Dates of Absences Due To Incident/Exposure: _____

Incident Witness?: ❑ Yes ❑ No Witness Name: _____

EMPLOYEE'S SIGNATURE CERTIFIES THAT INFORMATION IS TRUE AND CORRECT

_____ _____
(Non-Electronic) Employee Signature *Date Signed*

_____ _____
(Non-Electronic) Nurse/Health Technician Signature *Date Signed*

_____ _____
(Non-Electronic) Supervisor/Principal Signature *Date Signed*

Risk Management Use Only