ORENDA EDUCATION

EMPLOYEE INJURY REPORT FORM

Texas Mutual Insurance | 2951 Williams Drive, Georgetown, Texas 78628 | **DOB:** _____
Policy# 0002020319 | 512-869-3020 | **HIRE DATE**: _____

EMPLOYEE FULL NAME: (Print): _____

POSITION (JOB TITLE): _____

DATE REPORTED: *(MM/DD/YY)* _____**DATE OF INJURY:** _____**TIME OF INJURY:** _____

NATURE OF INJURY: _____

LOCATION: *(Circle one):* Gateway Prep - Gateway Tech – Nolan Creek – Kingsland – New Horizon – District

WORKSITE LOCATION OF INJURY (stairs, dock, etc) _____

CASE OF INJURY: (fall, tool, machine, etc) _____

_____

HOW AND WHY INJURY/ILLNESS OCCURED: _____

_____

_____

LIST OF WITNESSES: *(Names)* _____

_____

WAS EMPLOYEE DOING HIS REGULAR JOB? Yes or No. (If not, please explain): _____

_____

RETURN TO WORK DAY/ EXPECTED (MM/DD/YY) _____**DID EMPLOYEE DIE?** Yes or No

PART OF BODY INJURIED (*Side of Body)* **___ Right or ___Left __ Center**

☐ **Head**	☐ **Arm**	☐ **Face**	☐ **Foot**
☐ **Chest**	☐ **Hand**	☐ **Eye**	☐ **Leg**
☐ **Neck**	☐ **Elbow**	☐ **Mouth**	☐ **Knee**
☐ **Groin**	☐ **Wrist**	☐ **Nose**	☐ **Hip**
☐ **Internal**	☐ **Fingers**	☐ **Teeth**	☐ **Ankle**
☐ **Stomach**	☐ **Thumb**	☐ **Ear**	☐ **Toes**
☐ **Ribs**	☐ **Shoulder**	☐ **Chin**	
☐ **Waist**	☐ **Muscle**	☐ **Cheek**	

☐ **Other (Specify)** _____

Supervisor's Name: _____

Employee's signature: _____

Nurse's Signature: _____