

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: _____ am pm Work Day Ends: _____ am pm

Date of Incident/Exposure/Diagnosis: _____ Time of Incident: _____ am pm

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