NEW HAMPSHIRE PUBLIC SCHOOLS
SCHOOL ADMINISTRATIVE UNIT #1

CONTOOCOOK VALLEY SCHOOL DISTRICT
OFFICE OF THE SUPERINTENDENT OF SCHOOLS
106 Hancock Road, Peterborough, NH, 03458-1197
603-924-3336

Kimberly Rizzo Saunders, Ed.D.
Superintendent of Schools
ksaunders@conval.edu

Ann Forrest, Ed.D.
Assistant Superintendent of Schools
aforrest@conval.edu

EMPLOYER'S FIRST REPORT OF INJURY

PLEASE NOTE: The following information and attached form must be filled out for all employees who experience an accident or injury while working at their job. State Law requires that a Report of Injury must be sent to the Department of Labor **within five days of the injury**. **Therefore, it is important that the form be completed the day of the injury and sent to the Human Resource Office immediately. Also, please be sure the Administrator has signed the form.** If you have any questions, contact Denise McLenon, ext. 2033.

ALL QUESTIONS ARE REQUIRED AND MUST BE ANSWERED

Name of Injured:_____
(First) (Middle Initial) (Last)

Date of Birth: _____ Gender _____

Address: (No. & St.): _____

City/Town: _____ State: _____ Zip: _____

Telephone: _____

Occupation when injured: _____

Date of Injury: _____ Time of Injury: _____

Date Supervisor Notified: _____ Name of Supervisor: _____

School/Building where injury occurred: _____

Describe fully how accident occurred and describe what you were doing when injured. ***Please be sure to describe the INJURY in detail***:

_____

_____

_____

_____

_____

Please Complete Reverse Side

Employer's First Report of Injury

Name of Witness(es): _____

Part(s) of body injured: _____

Has injured returned to work:

- YES _____ Date returned to work: _____
- NO _____ Date Disability Began: _____

  Estimated Length of Disability: _____

Equipment causing injury: _____

Initial Treatment (check those that apply):

No medical treatment: _____ Care provided by employer only (on-site): _____

Emergency care: _____ Hospitalized: _____ Outpatient: _____

Clinic: _____ Office Visit: _____

Other – explain: _____

_____

Name of treating physician: _____

Name of treating hospital: _____

_____ Date: _____
Signature Administrator/Supervisor

_____ Date: _____
Signature of Employee