ARLINGTON HEIGHTS SCHOOL DISTRICT 25

INCIDENT REPORT

ALL spaces must be filled out.

This report **must be completed and returned to the Business Office within 24 hours** of the incident.

Injured Employee:		
Date & time of incident:		
Location where incident occurred (building and area of building):		
Cause of incident (i.e. fall, bite, cut, etc.):		
Nature of injury (i.e. laceration, sprain, contussion, etc.):		
Part of body affected (i.e. left forearm, lower back, etc.):		
Describe clearly, and with as much detail as possible, what happened (***must*** *include what employee was doing, object or substance responsible for injury, how/why the incident occurred, etc.)* Continue on additional page if necessary:		
Describe any hazardous conditions involved, or unsafe actions on the part of injured employee or any other party:		
Name/s of any witnesses:		
Indicate treatment received: ☐ None required ☐ Refused ☐ First aid only ☐ Treatment facility visit ☐ Physician visit ☐ Emergency room visit		
If treatment was not received, does employee plan to seek medical treatment? NO ☐ YES ☐	If YES, when?	
If medical treatment was received, list name, address and phone number of treatment facility, physician and/or hospital:		
Any other pertinent information not listed above:		
Person/s first notified of incident (i.e. supervisor, nurse, secretary, etc.):	Date and time incident first reported:	
Report prepared by:	Title & phone:	Date:
Employee's signature:		Date:
Administrator's signature:		Date:

Return report to Stacey Mallek by fax 847-660-6355 or email smallek@sd25.org