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LEE'S SUMMIT R-7 SCHOOL DISTRICT
EMPLOYEE INJURY - INCIDENT REPORT

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This report must be completed and filed with Business Services immediately upon incident or no later than 24 hours of incident. Telephone: 816-986-1049, 816-986-1048, or 816.329.9353, After hours: 816-329.9353, Fax: 816-986-1168

Section I: (Completed by Employee)

Employee Name: Employee ID:

Date of Birth: Gender: FEMALE MALE

Home Address: Home Phone:

Home City, State and Zip Code: SELECT FROM BELOW -

Cell Phone: Work Phone:

Regular Occupation: Department:

Regular Work Location: SELECT FROM BELOW - - -

Exact Location of Incident:

Date of Incident: Time of Incident: AM PM

Time Work Began on Day of Incident: AM PM

Did the injury occur while you were on duty? YES NO

Did the injury occur as a result of your required job activities? YES NO

Have you received training in the operation of equipment or technique used related to the injury?
YES NO

Have you followed proper reporting procedures? YES NO

Occupation When Injured:

Describe how incident occurred: (Who, where, what, when, why, how. If lifting, state what you were lifting and the approximate weight of object)

Were there witnesses to the injury? YES NO If so, list name(s) and telephone number(s):

Section II: (Completed by Employee)

Was first-aid treatment required:	YES	NO
Refused medical treatment:	YES	NO
Received treatment in school's health room:	YES	NO
Received treatment in District's Employee Health Clinic:	YES	NO
Required additional non-emergency medical treatment:	YES	NO
Required emergency medical treatment:	YES	NO

If treatment not required or refused, please provide details:

Section III: (Completed by Employee)

Part(s) of Body Affected - RIGHT LEFT

Head		Ear			Wrist		Knee
Eye		Back			Hand		Ankle
Nose		Arm			Finger(s)		Foot
Mouth		Elbow			Leg		Toes

Other (Specify):

Employee Signature (if physically able) Date

Supervisor Signature Date

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(Over)

Section IV: R-7 Health Services (For use by nurse only)

Vital Signs: T _____ BP _____ P _____ R _____

Treatment: _____

_____

Nurse's Notes: _____

_____

_____

Nurse's Signature: _____ Date: _____

EMPLOYEE INJURY RESPONSE PROCEDURES

Regular Business Hours: If the incident/accident occurs during regular school operation hours, then the employee should go to the nearest Health Services room for evaluation by a District Nurse, if applicable. If the case involves first aid only, Health Services staff can treat the employee at the site. If further medical treatment is needed, the District Nurse will get authorization from Business Services and the employee will be directed to:

Complete Health & Wellness Center: 600 NW Murray Road, Suite 103, Lee's Summit, MO 64081

Hours of Operation: Monday - Thursday: 7:00 am - 11:30 am and 12:30 pm to 6:00 pm
Friday: 7:00 am to 12:00 pm Saturday: 8:00 am - 11:00 am

Telephone: 1.877.423.1330

Complete Health & Wellness Center is the **official medical treatment provider for the Lee's Summit R-7 School** District. The District's workers' compensation insurance company (MUSIC) or its representatives will direct all other medical care on an as needed basis.

After Hours: Employees who are injured after regular business hours need to report the incident to their immediate supervisor. After hours care is available at:

The Urgency Room:
2741 NE McBaineDrive, Lee's Summit, MO 64064
Hours of Operation: Mon - Thurs: 8:00 am - 8:00 pm
Fri - Sun: 8:00 am - 10:00 pm
Telephone: 816.994.3786

Care Now:
228 NW Oldham Pkwy, Lee's Summit, MO 64081
Hours of Operation: Mon - Sun: 8:00 am - 8:00 pm
Telephone: 816.600.4075

After Hours: In the case of a serious or life threatening injury, report to one of the Emergency rooms listed below or call 911.

Lee's Summit Medical Center
2100 SE Blue Parkway, Lee's Summit, MO 64063
Telephone: (816) 282-5000 Fax: (816) 282-5942

Saint Luke's East Hospital
100 NE Saint Luke's Blvd, Lee's Summit, MO 64086
Telephone: (816) 347-5000 Fax: (816) 932-6207

For District Central Office Use Only:

Employee SSN: _____ Report Number: _____
Hire Date: _____ Date Reported: _____
Full Time: _____ Part Time: _____ Claim Number: _____
Hourly Rate of Pay: _____ First Three Days: _____
Annual Salary: _____ Notes:
Job Description Provided YES NO
Wage Statement YES NO

Revised 11/3/17