


ACTEC REPORTING SERVICE 1-877-607-8600

Call the Phone Number Above to Report On-the-Job Incidents/Injuries

 BALTIMORE CITY PUBLIC SCHOOLS	<h2 style="margin: 0;">EMPLOYEE INCIDENT REPORT</h2>	Employment Status <input type="checkbox"/> 10 Month Employee <input type="checkbox"/> 12 Month Employee <input type="checkbox"/> Full Time Employee <input type="checkbox"/> Part Time Employee <input type="checkbox"/> Temporary Employee <input type="checkbox"/> Other <input type="checkbox"/> Union Code
INSTRUCTIONS		1. Date of this report
IF EMPLOYEE IS SENT TO CLINIC: Complete all portions of this form before sending employee to Clinic. Remove "Agency Copy" for files. Send remaining copies with employee to clinic.		2. Date: Month Day Year
IF EMPLOYEE IS SENT TO HOSPITAL: Complete all portions of this form immediately after sending employee to the nearest medical facility for treatment. Remove "Agency Copy" for files. Send remaining copies to Clinic.		Incident Occurred Time Shift
NOTE; "AGENCY COPY" REQUIRES ADDITIONAL ACTION AFTER REMOVAL!		
3. Social Security Number	4. Employee's Name Last	First Middle Init.
5. Title	6. Home Address	7. Home Phone Work Phone
8. Agency	9. Division, Region, District, Unit, etc.	10. Agy Code 11. Loc. #
12. Date of Birth	13. Age	14. Sex <input type="checkbox"/> F <input type="checkbox"/> M
15. Date of Employment Date assign to present job		16. Gross Rate of Pay \$ PER Hr./Day/Wk.
17. DISPOSITION <input type="checkbox"/> CLINIC <input type="checkbox"/> HOSPITAL	Name of Clinic/Hospital	Date Admitted Discharge Date
18. Physician's Name Printed	Physician's Signature	Phone
19. Specify exact address where incident occurred. Also specify exact location at this address		
20. Describe fully, in employee's words, how incident occurred (use additional signed sheets if necessary)		
21. According to employee, what part(s) of his/her body were injured?		
22. Employee Signature Date <input type="checkbox"/> Check here if employee is unable to sign		
23. Is the employee's statement in accordance with Supervisor's knowledge of the facts <input type="checkbox"/> Yes <input type="checkbox"/> No If No, explain fully the details of incident in your own words (use additional sheets if needed)		
24. Was safety equipment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was it in use at the time? <input type="checkbox"/> Yes <input type="checkbox"/> No		26. Was incident caused by injured's failure to observe safety rules? Yes No
27. SCHOOL/LOCATION EMERGENCY CONTACT PHONE NO.		28. When did you first learn of Incident? Date Time AM/PM
PERSONAL EMERGENCY CONTACT PHONE NO.		29. If fatality, show date here
Witness (es) Name(s)	City Schools Employee Yes/No	Address Phone
Supervisor's Title	Signature	Date

UNION CODES: T=TEACHER P=PARA A=PSASA 6=UNAFFILIATE U=CUB 1=LOCAL 44