

Marshall County Schools

Employee's Report of Injury

Employee Name _____

Date of Injury _____ Time started work on date of injury _____

Did employee seek outside medical attention? _____ No

_____ Yes

Medical treatment sought at: _____ Reynolds Memorial Hospital ER
 _____ Wheeling Hospital ER
 _____ Ohio Valley Medical Center ER

Description of Injury (please provide date, time and a detailed description of how the injury occurred and what body parts were injured.....including left or right description) On _____ (date)

At about _____ (time), I was injured when I _____

This incident was witnessed by (name of individual(s) who saw incident)

 Employee Signature

 Date Reported

 Supervisor Signature

 Date Received

Please report/submit to supervisor within 24 hours of injury. Supervisor is to fax form immediately to the County Office at (304)843-4863. Thank you.

