# CITY OF SAINT PAUL

**EMPLOYEE'S SAFETY REPORT** **INJURY OR AGGRAVATION**

If you treat with a doctor or lose time from work, please notify your supervisor.

EMPLOYEE MUST SUBMIT THIS REPORT WITHIN 24 HOURS OF WORK-RELATED INJURY OR AGGRAVATION

**DEPARTMENT** _____ **DIVISION** _____ **ACTIVITY CODE** _____

1. First Name _____ Middle Name or Initial _____ Last Name _____
2. Telephone: Home _____ Work _____Cell_____
3. Street Address _____ City _____ State_____ Zip_____
4. Date of Birth _____ ☐ Male ☐ Female Marital Status _____
5. COSP Employee Number _____ Last four digits of social security number _____
6. Job Title _____ Salary $_____ ☐ Hourly ☐ Bi-Weekly
7. Job Status ☐ Full Time ☐ Part Time ☐ Temporary ☐ Intern ☐ YJC ☐ Volunteer
8. Scheduled days worked (circle) ☐ SU ☐ M ☐ TU ☐ W ☐ TH ☐ F ☐ SA ☐ Rotating
   Fire Shift (circle) A B C Police (circle) Midnight Days Afternoon Average Hours Per Week: _____
9. Do you have another job? ☐ No ☐ Yes
   If yes, company _____
   Position_____ Salary _____

## INJURY INFORMATION

10. Date of injury _____ Time employee started work _____ Time of injury _____
11. Exact location where injury occurred (street address) _____
12. Was injury on city property? ☐ Yes ☐ No
13. Date injury reported to supervisor _____ Was time lost on Date of Injury? ☐ No ☐ Yes
    First day lost (date) _____ Return to work, actual or expected (date) _____
14. Was medical treatment given? ☐ Yes ☐ No If yes, ☐ First aid only ☐ ER visit or other ☐ Clinic visit
15. Provide name and address of physician and/or hospital: _____
16. Nature of injury (cut, sprain, burn, etc.) _____
17. Part(s) of body injured ☐ Left side ☐ Right side_____
18. What caused injury to occur?

| | | | | |
|---|---|---|---|---|
| ☐ Ground | ☐ Motor vehicle | ☐ Wet Floor | ☐ Other Person | ☐ Stairs |
| ☐ Animal/Insect | ☐ Hand Tool | ☐ Powered Tool | ☐ Foreign Object | ☐ Chemicals |
| ☐ Bodily Fluids | ☐ Computer | ☐ PPE or Lack of PPE | ☐ Other (Specify)_____ | |

19. Written Description of Injury
    _____
    _____
    _____
    _____
    _____
20. Do you have a prior injury to this body part? ☐ No ☐ Yes When?_____
21. Do you have a prior Workers Compensation claim on this body part? ☐ No ☐ Yes When? _____
22. If aggravation, what caused resumption of symptoms? _____
    _____
23. Did prior injury or disability contribute to this injury? ☐ No ☐ Yes Explain? _____
    _____
24. Witnesses (names and phone numbers) _____
    _____

**I certify that all statements in this report are true** _____ **Date** _____

**(Employee Signature)**

Supervisor's Name (Print) _____

Supervisor's Signature _____ Date_____

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**DEPT AND SPVRS SHOULD KEEP A COPY OF THE COMPLETED FORMS BEFORE SENDING THEM TO WORKERS COMPENSATION**

**DEPARTMENT VIA FAX: 651/266-8886 OR EMAIL: WorkersCompensation@ci.stpaul.mn.us**