CITY OF HAMPTON AND HAMPTON CITY SCHOOLS
Report of Work-Related Injury or Illness Form
EIR FORM 1000

REVISED DECEMBER 2022

THIS FORM MUST BE SUBMITTED TO RISK MANAGEMENT WITHIN 24 HOURS OF THE INJURY
Email: Risk Management
risk_management@hampton.gov
Please make sure to reference your department's directive for additional reporting guidance.

EMPLOYEE INFORMATION

THIS FORM IS TO BE COMPLETED BY THE EMPLOYEE

Name of Employee (Last, Middle, First):	Social Security Number:	Sex: Male ☐ Female ☐

Date of Birth:	Employee Mailing Address:	Employee Contact No.:

Job Title:	Employee No.:	Department and Division:	Supervisor Name and Phone No:

INJURY OR ILLNESS INFORMATION

Date of Injury or Illness:	Time of Injury or Illness: ☐ AM ☐ PM	Time began work: ☐ AM ☐ PM

Location where injury or illness occurred (please give as much detail as possible):

To whom was the injury reported please include name, title, and phone number:	Date Injury or Illness Reported:

INCIDENT TYPE INFORMATION

Please check all that apply below

☐ Bitten/Punctured	☐ Caught In/On/Between	☐ Fall on Stairs	☐ Fall Flat Surface
☐ Struck by	☐ Inhalation	☐ Lifting	☐ Pushing/Pulling
☐ Slip but did not fall	☐ Slipped and Fell	☐ Illness (nausea, etc.)	☐ Temperature
☐ Bending	☐ Driving/Riding	☐ Standing	☐ Walking
☐ Running	☐ Sitting	☐ Squatting	☐ Other:

BODY PARTS AFFECTED

Please check all that apply below

RIGHT SIDE	☐ Abdomen	☐ Groin	☐ Toes	☐ Foot	☐ Ankle	☐ Wrist	☐ Arm	☐ Head
RIGHT SIDE	☐ Lower Back	☐ Upper Back	☐ Neck	☐ Shoulder	☐ Elbow	☐ Eye	☐ Ear	
RIGHT SIDE	☐ Hip	☐ Mouth	☐ Teeth	☐ Chest	☐ Leg	☐ Nose	☐ Hand/fingers	Other:
LEFT SIDE	☐ Abdomen	☐ Groin	☐Toes	☐ Foot	☐ Ankle	☐ Wrist	☐ Arm	☐ Head
LEFT SIDE	☐ Lower Back	☐ Upper Back	☐ Neck	☐ Shoulder	☐ Elbow	☐ Eye	☐ Ear	
LEFT SIDE	☐ Hip	☐ Mouth	☐ Teeth	☐ Chest	☐ Leg	☐ Nose	☐ Hand/fingers	Other:

Please give detailed description of how injury or illness occurred below:

Please choose from the list of providers below. You must choose even if you decide not to seek treatment at this time.

Dr. Roxanne Dietzler ☐	**Dr. Cynthia Dorr** Concentra	**Dr. Maulin Desai Patient First** ☐	**Dr. Michal Baddar I & O Medical Center** ☐	**Dr. Robert Dearnley Velocity Urgent Care** ☐

Was first aid provided? ☐ Yes ☐ No	**Are you seeking medical treatment at this time?** ☐ YES ☐ NO

Signature of Employee:	**Date:**
Signature of Supervisor:	**Date:**

ALL SECTIONS OF THIS FORM MUST BE COMPLETED OR IT WILL BE RETURNED

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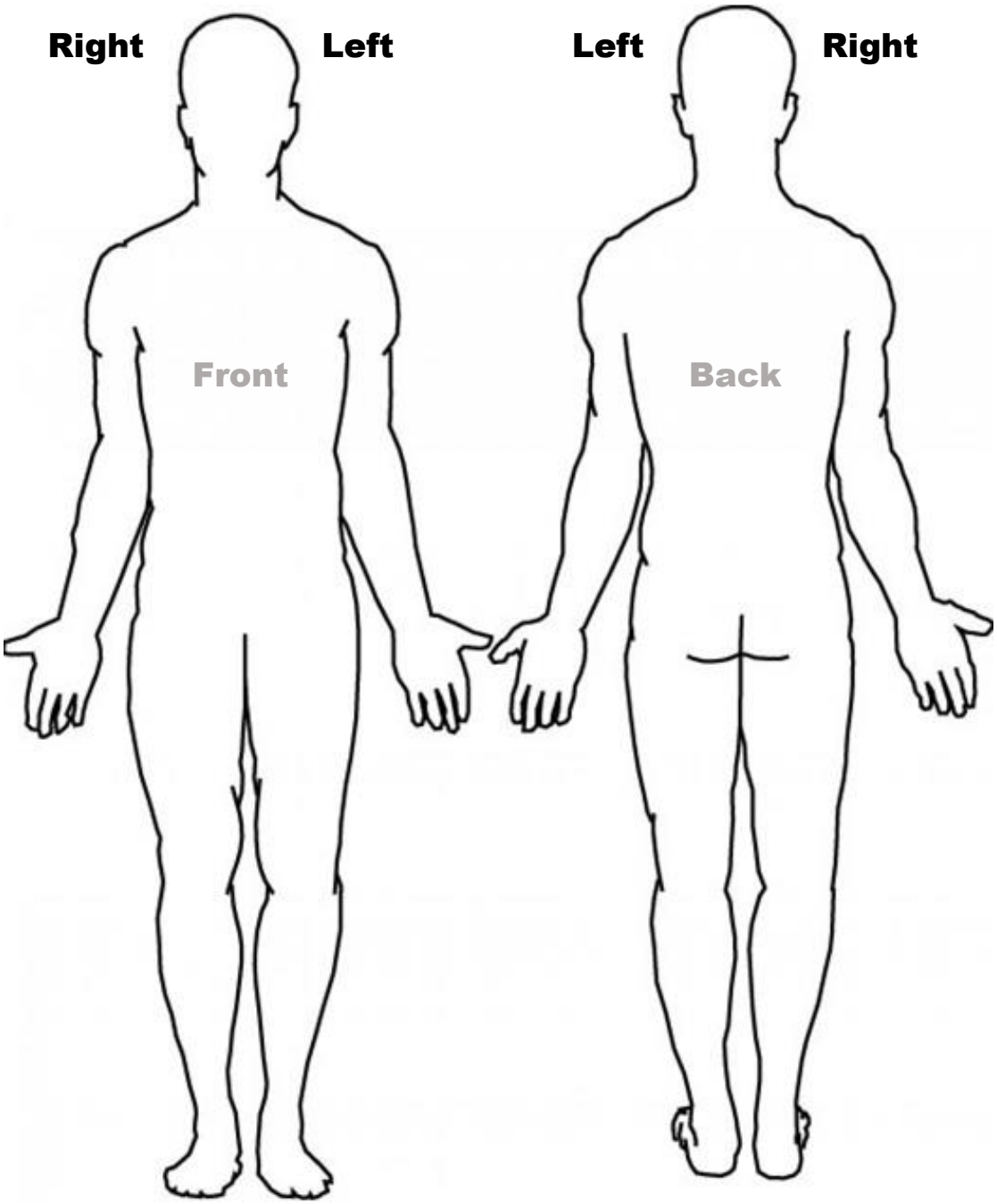
Name of Employee (Last, Middle, First): **Date of Injury or Illness:**

Please circle and initial the area on the body map that was injured.



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