

IN LIEU OF REPORTING YOUR CLAIM TO TRAVELERS AT 800-832-7839

Employee First Report of Injury or Illness

Madison Metropolitan School District
545 West Dayton Street, Madison, WI 53703

FEIN: 39-6003202
Phone: 608-663-1692 / Fax: 608-204-0346

EMPLOYEE INFORMATION			
Name		B Number	
Address (city, state, zip)			
Home/Cell Phone		Gender	
Date of Birth		Social Security Number (required)	*required*
Employed Elsewhere?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Where?		

EMPLOYMENT INFORMATION			
Date of Hire		Scheduled Work Hours	: AM PM to : AM PM
Job Title		Unit (Former Bargaining Unit)	
Work Location		Location Code	
Business Type	Education	County	Dane

INJURY/ILLNESS INFORMATION				
Date of Injury		Time of Injury	: AM PM	Specific Location
Describe How the Injury/Illness Occurred				
Tools/Objects/Chemicals/Etc Involved in the Injury/Illness		Body Parts Affected and How Each Was Affected	Was the injury student induced?	
Witness(es) Name(s)		Witness(es) Phone #		
Have You Previously Had Any Problems with the Injury Area(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Please Describe Including Dates:			

MEDICAL TREATMENT INFORMATION				
Did you Seek Out of District Medical Treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No *Call 608-663-1692 if you later decide to seek treatment	Date of First Medical Treatment		
Name of Treating Provider		Phone Number		
Address (city, state, zip)				
Were You Treated in an Emergency Room?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Were You Hospitalized Overnight?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are You Missing Time From Work?	<input type="checkbox"/> Yes <input type="checkbox"/> No	First Day Missed		Estimated Return To Work Date

All time away from work (including any related appointments) and Notice of Restrictions must be documented in writing by a licensed Physician/Medical doctor. Notes from a Nurse Practitioner (APNP) or Physician's Assistant (PA-C) will not be accepted.

Inform your medical provider that MMSD does have light duty/restrictive work assignments available. Provide the treating physician with a Work Status Report form to complete for documentation of restrictions or lost time.

I attest that the information documented on this form is true and to the best of my knowledge.

Name of Person Completing Form		Date Completed	
Signature			

MMSD is self-insured for workers compensation

Insurance Carrier: Travelers, PO Box 3205, Naperville, IL 60566; Fax 877-786-5567