WAKULLA COUNTY SCHOOL BOARD
WORKER'S COMP BAND-AID FORM

Injury Date:_____ Time:_____ Date Reported:_____

Name:_____ SSN:_____ School Ctr:_____

Position:_____ DOB:_____ H Phone:_____

Home Address:_____City/State/Zip_____

Explanation of accident:

_____

Injured Employee:_____/_____
(Print) (Signature)

School/Dept W/C Contact:_____/_____
(Print) (Signature)

The collection of the social security number on this form is specifically authorized by Section 440.185(2), Florida Statutes. The social security number will be used as a unique identifier in Division of Workers' Compensation database systems for individuals who have claimed benefits under Chapter 440, Florida Statutes. It will also be used to identify information and documents in those database systems regarding individuals who have claimed benefits under Chapter 440, Florida Statutes, for internal agency tracking purposes and for purposes of responding to both public records requests and subpoenas that require production of specified documents.