Employer Information Form

Company Name: Faribault Public Schools

Name of Injured Employee: _____

Form Completed By: _____

Date of Injury: _____

Today's Date: _____

Injured Employee's Job Title: _____

Policy Number: 10139009WC

Does Injured Employee Work Full or Part Time? _____

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1. LOST TIME

Did the injured employee lose any time from work? Yes ____ No_____

Did the employee leave work to seek medical treatment? Yes ____ No ____

If yes, did he/she return to work after the appointment? Yes ____ No ____

When is the employee's next scheduled shift? _____

If the employee is disabled from working, when is his/her anticipated return to work date? _____

Please indicate the date(s) the employee missed work and the number of hours on each day.

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2. MEDICAL TREATMENT

Did the employee seek medical treatment? Yes ____ No ____

If yes, where? _____ Phone Number: _____

If no, does the employee intend to seek medical treatment? Yes ____ No ____

Is a follow-up doctor appointment scheduled? Yes ____ No ____

If so, when and where? _____

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3. WORK STATUS

Is the employee currently working? Yes ____ No ____

Does the employee have work restrictions? Yes ____ No ____

If yes, please fax a copy of the work restrictions to State Auto at 800-563-3384.

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4. OTHER

Are there any concerns or issues with the employee or with the nature of the injury? Yes ____ No ____