Employee's Report of Work Injury /Illness

Please report injuries within 24 hours

Complete all areas of this form and return to your supervisor.

Name:	SSN:	Date of Birth:
Address:	City:	Zip:
Phone:	Cell:	❒ Male ❒ Female
Job Title:	Site:	Time begin work:

Date incident occurred: _____ Time incident occurred: _____

Site or address where incident occurred? _____

Did the incident occur on school property? ❒ No ❒ Yes

Describe the incident (include what happened, what you were doing, any equipment you were using): _____

_____

_____

_____

Describe the injury (include the exact part of body injured): _____

_____

_____

Provide name, address and phone number of any witnesses: _____

_____

_____

Have you ever been treated for a similar injury/illness? ❒ No ❒ Yes – if yes, list the date and name and address of treating doctor: _____

Please provide any recommendations you have for preventing this type of accident: _____

_____

I declare under penalty of perjury that the foregoing is true and correct.

❒ I do not require or desire medical attention at this time. I understand that if within one year of the date of occurrence I feel the need for medical attention, I may initiate it by contacting the Employee Benefits Specialist at 389-2100 ext 1164. I received the attached Worker's Compensation Claim form and the Medical Service Order.

❒ I do require medical attention at this time. I have completed the Worker's Compensation Claim form and have received the Medical Service Order. Please contact your supervisor immediately to initiate medical attention.

Employee's Signature: _____ Date: _____

If you receive medical attention, you must submit a doctor's note to HR before returning to work.