ALL FIELDS MUST BE COMPLETED

Workers' Compensation

MOUNT OLIVE TOWNSHIP SCHOOL DISTRICT

School:

Employee Injury and Illness Report

FORM MUST BE FILLED OUT COMPLETELY

EMPLOYEE SEEKING TREATMENT OUTSIDE OF SCHOOL NURSE?

CLAIM CALLED IN or REPORTED ONLINE?

IMPORTANT!

I certify that the statements made by me are true and correct. I am aware that if any of the statements are willfully false, I may be subject to disciplinary action by my employer.

By initialling the box and dating, I certify the above statement to be true.

Initial:

Date:

For office use:

# of Days Out of Work:

Information about the employee:

Full Name:

Street:

City: State: Zip:

Telephone Number:

Email Address:

Job Title:

Date of Birth:

Date of Hire:

Salary:

Full Time or Part Time

10 months or 12 months

Primary Care Physician:

Primary Care Physician Location:

Witness Information:

Age of student if child was involved: Special ED?

If this was a hand/arm injury, please indicate dominant hand:

If this was a bite or scratch, was skin broken?

(If yes, Hepatitis B vaccine recommended)

To whom did you first report injury to and when:

If treatment was given away from the worksite, where was it given?

Facility:

Facility Location:

Information about the incident:

Date of Injury or Illness:

Exact location of Incident in building:

Time employee began work:

Time of event:

☐ (Check box if time cannot be determined)

What was the employee doing just before the incident occurred?

What happened?

What body part was injured?

What object or substance directly harmed the employee?

All head injuries MUST have concussion phone evaluation performed by NJSIG

Past treatment for same or similar medical condition?

Treated by a chiropractor in the past?

Prior Workers Compensation claims filed?

Prior Motor Vehicle accidents?

Other employment while employed by MOBOE?

Participate in athletic, recreational or sporting activities?

Prior Pain Management treatment?

If yes to any of the above questions, please explain:

Employee Signature: Date:

Supervisor Signature: Date:

*****After completion - print form, initial "Important" box, sign "Employee Signature", then have Nurse/Supervisor sign.*****