CM REGENT™
INSURANCE COMPANY

Workers' Compensation Division

Internal School District Work-Related Incident Report

Section One: Employee and Incident Information

Employer Name:	Employer Address:	County:
Elizabeth Forward School District	401 Rock Run Rd.	Allegheny

Employee Name (last, first, initial):	Home Phone #:	Gender: M ☐ F ☐	Marital Status: M ☐ S ☐ D ☐ W ☐

Home Address (street, city, state, zip code):	County:

Social Security #:	DOB:	Date of Incident:	Time of Incident:	Date Reported:	To Whom Reported:	Start Time:

Location of Incident (building, room, etc.):	Type of Injury (cut, sprain, etc.):

Injured Body Part:	Cause of Injury (machine, tool, equipment, liquid, etc.):

Employee's Job Title:	Hours Worked Per Week:	Name of Witness(es):

Description of Incident (please describe in detail what happened):

Employee Name:	Employee Signature:	Date:

Employee's Supervisor Name:	Employee's Supervisor's Signature:	Date:

Section Two: No Medical Treatment

☐ Returned to Work ☐ Returned to Work with Modified Duties ☐ Sent Home

Supervisor's Signature: Date:

Section Three: Medical Treatment or First Aid

Type of Injury: _____ ☐ New ☐ Other (describe): _____

Treatment/First Aid: _____

Diagnosis: _____

Disposition: _____

☐ Return to work without limitations

☐ Return to work with limitations (describe): _____

☐ May return to work on: _____

☐ Follow-up appointment with: _____ on _____

Signature of medical/first aid provider _____ **Date:** _____

Medical Facility Address:

300 Sterling Parkway, Suite 100, Mechanicsburg, PA 17050
844-480-0709 Fax: 866-402-6601 www.CMRegent.com