



Complete this form immediately for all accidents reported by employees acting within the line and scope of employment. **Please submit completed form to payroll@chickasawschools.com**

1. Name of Injured Employee (please type or print) (Last) (First) (MI)		2. Social Security Number		3. Date of Birth		4. Sex _____M _____F	
5. Home Address Work: Years on Present Job _____		6. Telephone Number Home Alternate		7. Job Title Years Employed _____ _____Contract (Y/N)		8. Status _____Full Time _____Part Time/Sub	
9. School/Department		10. Agency Address: Chickasaw City School 201 N. Craft Hwy Chickasaw, AL 36611					
11. Date of Injury		12. Time of Injury		13. Date & Time Supervisor Notified		Did Employee continue to work at assigned tasks after accident _____Y _____N	
14. Is employee covered by medical insurance? _____Yes _____No If yes: _____Blue Cross/Blue Shield _____Other Insurance Name: _____		15. Name and address of attending Physician					
16. Name and address of medical facility where treated _____Hospitalized _____Outpatient _____Emergency Treatment		17. City or town where injury occurred		18. Location/place where injured. School/Dept., Be specific, i.e, which classroom, office, where on grounds, etc.			
19. Did Employee seek medical treatment: _____Immediately _____During Work Hours _____After Work Hours							
20. Describe fully what happened to cause the injury or illness.							
21. Describe the injury or illness in detail and indicate the body part(s) affected:							
22. 1 ST Aide/Treatment Employee received:							
23. Were there any witnesses to the injury? _____Yes _____NO (If "yes", give name, address, and telephone number)							
24. _____ Signature of Injured person _____Print Name _____Daytime Telephone Number _____Date							
25. INVESTIGATION OF THE ACCIDENT: TO BE FILLED OUT BY THE ADMINISTRATOR/SUPERVISOR ONLY (Attach additional sheets if needed) How did the accident happen? What was the employee doing? _____ Signature of Supervisor _____Print Name _____Daytime Telephone Number _____Date							
For Central Office Use Only : Employee Paid For: _____hrs/days Days Used _____Date Returned to Work Full Status							



CHICKASAW CITY SCHOOLS

JOB-RELATED INJURY PROGRAM PHYSICIAN STATEMENT

1. Name of Injured Employee (please type or print) (Last) (First) (MI)	2. Social Security Number	3. Date of Birth	4. Sex ____M ____F
5. Home Address	6. Telephone Number Home () Work ()	7. Job Title	8. Status ____Full Time ____Part Time ____Contract
9. Treating Physician	10. Agency Address: CHICKASAW CITY SCHOOLS 201 N. CRAFT HWY Chickasaw, AL 36611		
11. Date of Injury Date Treated	12. Is there a reasonable expectation that employee will be able to return to work ____Y ____N	13. If "yes" on item 12, give the date or approximate date of return	
Diagnosis and Probable Cause:			
Was This Condition Present Prior To Injury? (circle) Yes No			
Condition Is Related To: (circle) Employment Non-Job Accident Other			
Treatment Ordered			
Follow Up Treatment			
14. If the employee can return to work, are there any restrictions on the employee's duties? YES NO			
LIGHT DUTY RESTRICTIONS:			
Lifting/Carrying	None Allowed	Maximum Pounds Allowed	_____
Standing, Sitting, Walking	None Allowed	Maximum Hours or % Allowed	_____
Bending, Stooping, Twisting	None Allowed	Maximum Hours or % Allowed	_____
Squatting, Kneeling	None Allowed	Maximum Hours or % Allowed	_____
Pushing, Pulling	None Allowed	Maximum Hours or % Allowed	_____
Climbing	None Allowed	Maximum Hours or % Allowed	_____
Reaching	None Allowed	Maximum Hours or % Allowed	_____
Use Of Upper Extremities	None Allowed	Maximum Hours or % Allowed	_____
Driving	None Allowed	Maximum Hours or % Allowed	_____
Environmental Exposure	Heat Cold Moisture	Maximum Hours or % Allowed	_____
Other:			
Beginning Date _____ Until _____			
15. If "no" on item 12, give details for employee not being able to return to work			
16.			
Signature of Attending Physician		Print Name	Telephone Number
			Date