WORKERS COMPENSATION CHECKLIST

Not Seeking Medical Attention

☐ First Report of Injury – This form is to be completed by the School Administrator – not the employee. Be sure to complete the Highlighted areas.

☐ Injury Statement – This form is to be completed by the injured employee.

☐ Voluntary Witness Statement – This form is to be completed by the person who witnessed the accident. Have the witness complete the form while the details are fresh.

*Fax the documents to HR at (228) 826-0179 within 24 hours of the employee's injury.

**NOTE: Failure to file Workers Compensation paperwork within the specified time could result in a fine levied against Jackson County School District by the Mississippi Insurance Department.

MWCC - WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)

Jackson County School District
P. O. Box 5069
Vancleave, MS 39565
Phone 228-826-0171 or 228-826-0172

CARRIER/ADMINISTRATOR CLAIM NUMBER

REPORT PURPOSE CODE

JURISDICTION

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)

LOCATION #

PHONE #

SIC CODE: 8211

EMPLOYER FEIN: 64-6000513

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO)

MS Municipal WC Group
600 East Amite Street, Suite 200
Jackson, MS 39201

POLICY PERIOD: 10/1/2025 TO 9/30/2026

CHECK IF APPROPRIATE
☑ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

MS Municipal WC Group
Phone# 800-898-1032
Fax# 601-355-8584

CARRIER FEIN

POLICY/SELF-INSURED NUMBER

ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)

DATE OF BIRTH

SOCIAL SECURITY NUMBER

DATE HIRED

STATE OF HIRE

ADDRESS (INCL ZIP)

SEX
- MALE (M)
- FEMALE (F)
- UNKNOWN (U)

MARITAL STATUS
- UNMARRIED/SINGLE/DIVORCED (U)
- MARRIED (M)
- SEPARATED (S)
- UNKNOWN (K)

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

PHONE

OF DEPENDENTS

NCCI CLASS CODE

RATE PER: DAY / WEEK / MONTH / OTHER:

#DAYS WORKED WEEK

FULL PAY FOR DAY OF INJURY? YES / NO

DID SALARY CONTINUE? YES / NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK AM / PM

DATE OF INJURY/ILLNESS

TIME OF OCCURRENCE AM / PM

LAST WORK DATE

DATE EMPLOYER NOTIFIED

DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER

TYPE OF INJURY/ILLNESS

PART OF BODY AFFECTED

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? YES / NO

TYPE OF INJURY/ILLNESS CODE

PART OF BODY AFFECTED CODE

COUNTY WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK

IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? YES / NO

WERE THEY USED? YES / NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL (NAME & ADDRESS)

INITIAL TREATMENT
- NO MEDICAL TREATMENT (0)
- MINOR: BY EMPLOYER (1)
- MINOR CLINIC/HOSP (2)
- EMERGENCY CARE (3)
- HOSPITALIZED > 24 HRS (4)
- FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED (5)

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED

DATE PREPARED

PREPARER'S NAME & TITLE

PHONE NUMBER

SEE BACK FOR INSTRUCTIONS

INJURY STATEMENT
(In your own words)

Name & Contact Number:

Date of Birth:

Email address:

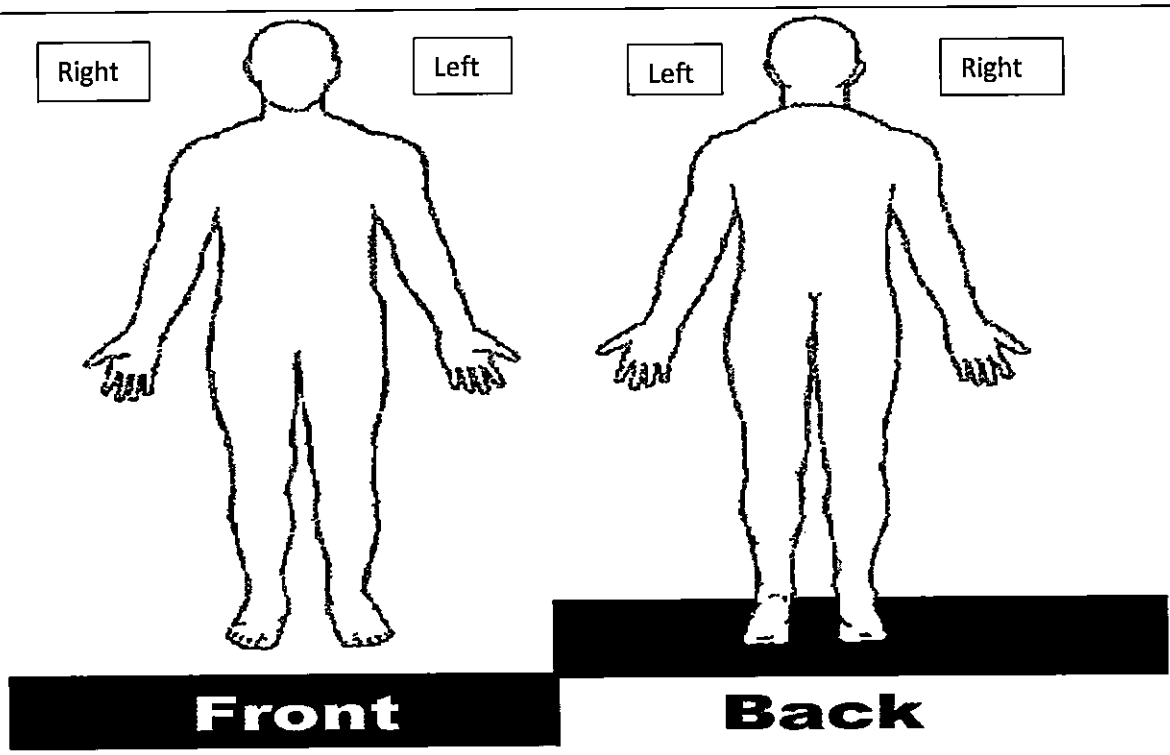
Occupation:

Employer's Name and Address:

Date, Time, and Place of Accident:

Describe in detail what you were doing and what happened when the accident occurred.

Describe your injury & Indicate location of injury on the Body Mapping Chart below:



Name and contact number of witnesses or person(s) having knowledge of accident

VOLUNTARY INCIDENT WITNESS STATEMENT

Injured Employee's Name: _____

Date & Time of Accident: _____

Name of School Campus: _____

Name of Witness: _____

Job Title: _____

Witness Contact Number: _____

Date & Time of Statement: _____

Did you see the incident occur? _____ **Yes** _____ **No**

If Yes, please describe what you observed in detail.

I affirm that the information above is complete and accurate to the best of my knowledge.

_____

Signature of Witness