# EMPLOYEE'S REPORT OF INJURY

## EMPLOYEE DATA

XXX-XX-_____ | _____ | _____
SOCIAL SECURITY NUMBER | DATE OF BIRTH | GENDER

_____ | _____
FULL NAME | PHONE

_____ | _____
ADDRESS | WORK LOCATION

## INJURY/MEDICAL DATA

_____ | _____
LOSS / INJURY DATE | DATE EMPLOYER NOTIFIED BY EMPLOYEE

_____
WORKSITE LOCATION OF INJURY

_____ | _____
TIME EMPLOYEE BEGAN WORK | TIME OF EVENT

Is the employee seasonal? ❍ YES ❍ NO

Did the employee die? ❍ YES ❍ NO

Will the employee miss more than 7 days of work? ❍ YES ❍ NO (This may be uknown)

How did the injury occur? _____

_____

_____
BODY PART(S) INJURED

## OCCUPATIONAL AND WAGE DATA

_____ | _____
OCCUPATION | HIRE DATE ( Completed by Payroll)

Pay rate: _____ ❍ HOURLY ❍ SALARY (Completed by Payroll)

Was medical treatment sought? ❍ YES ❍ NO

Where was medical treatment sought? _____

## PREPARER INFORMATION

_____ | _____
FULL NAME | PHONE

_____ | DEXTER COMMUNITY SCHOOLS
EMAIL | COMPANY NAME

## SIGNATURE

_____ | _____ | _____
SIGNATURE | DATE | CLAIM #

8/2025