

EMPLOYEE ACCIDENT / ILLNESS REPORT

(Revised July 2026)

Notice Regarding Worker's Compensation Eligibility: The injured employee or his/her immediate supervisor must complete and submit this accident report to the designee of the Principal or Facility Supervisor within **24** hours after the accident; AND the injured employee must see a physician designated as a Forsyth County Board of Education Worker's Compensation physician within **48** hours after the accident, OR if the injury occurred after doctor's hours and the injury requires immediate medical attention, the injured employee must report to the nearest emergency room.

Directions for the Employee and Principal or Facility Supervisor: Retain Original at School/Facility and Fax/Email Copy to Workers' Comp

(1) ALL employee accidents requesting medical treatment must complete injury report. For non emergent injuries requiring medical treatment, you **must first complete and submit an injury packet to Work Comp prior to medical treatment being authorized. Emergency situations needing authorization for treatment, please contact Finance Department (770-887-2461 x202140/workerscomp@forsyth.k12.ga.us) ASAP by your designee**

(2) Direct the injured employee or his/her immediate supervisor to complete and return this **accident report** to your designee within **24** hours; fax: **(470-695-7834)**

Email: workerscomp@forsyth.k12.ga.us After hours authorization for medical treatment call 1-800-444-9098 option 1

(3) Take appropriate corrective action designed to prevent or reduce the risk of a similar accident whether with Facilities or Transportation.

Information about the Accident

School or Facility Name: _____ Accident Date: _____ Accident Time: _____ AM/PM

Full Name of Person Involved in the Accident: _____ EMPLOYEE ID _____

Cell Phone Number of Person Involved in Accident: _____ Email (FCS) of INJURED: _____@forsyth.k12.ga.us

When did the supervisor/administrator first have knowledge of the injury? Date: _____ Time: _____ AM/PM

Location of Occurrence (please circle) On Premises Off Premises On Approved Route

Job Description: (please circle) Administrator Secretary/Clerk Custodian Food Service Maintenance Bus Driver Bus Monitor

Paraprofessional SPED Paraprofessional Teacher SPED Teacher Other (Specify Other) _____

List Nature Of Injury/Illness (Strain, Laceration, Burn, Fracture, _____)

List Part of Body (Back, Finger, Hand, Foot, etc. Please be specific left, right front back, upper lower, etc) _____

Employee Went : (please circle) Home Hospital Panel Physician Back to Work Nurse Other

If Nurse or other please give details _____

1. Please describe the accident (**be descriptive**):

2. Have you had a prior injury or condition to the injured body part? Yes No If YES, please explain

3. Do you have any medical conditions prior to the accident? Yes No If YES, please explain

4. Did anyone witness the accident? Yes No If YES, please explain

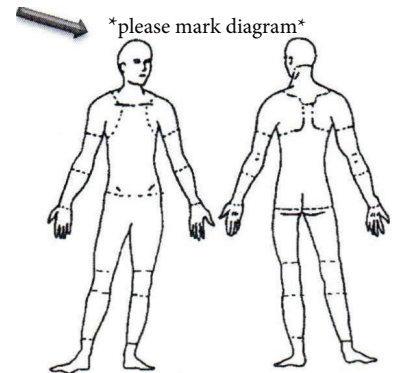
5. What could have been done to prevent the injury?

6. Did you select a doctor from our panel of physicians? Yes Incident Only If incident only, state why you do not want to seek treatment:

Employee Signature: _____ Date: _____

Immediate Supervisor Signature (if applicable): _____ Date: _____

Principal or Facility Supervisor Signature: _____ Date: _____



Forsyth County Schools Supervisor/Administrator Report

(Revised July 2025)

To Be Conducted by the School Safety Coordinator or Another Administrator. Please complete within 24 hours.

MANAGER REPORT

Injured Employee Name: _____ Date of Injury: _____

Medical: Did the employee receive treatment outside of our posted panel of physicians? Yes ☐ No ☐

If **YES**, did the employee go to the emergency room? Yes ☐ No ☐

Emergency Room: _____

Why did the employee go to the emergency room?

If **NO**, where did employee go for medical treatment (we need to know why they did not go to a panel doctor):

Did the employee go alone to seek medical treatment? Yes ☐ No ☐ If NO, who went? _____

Red Flag Analysis (please give an explanation for every box checked) If no Red Flags check here ☐

- ☐ There were conflicting descriptions of what happened.
- ☐ The employee had health concerns that may have contributed to the incident.
- ☐ The employee had a history of injuries
- ☐ The employee had missed days or reported sick prior to the injury
- ☐ The claim was unwitnessed. If No were witness statements obtained? Yes ☐ No ☐
- ☐ The employee has had previous workers' compensation claims.
- ☐ The employee delayed reporting.
- ☐ The Supervisor delayed reporting.
- ☐ The employee works somewhere else.
- ☐ The employee may have been injured away from work.
- ☐ The employee has had a history of disciplinary actions.

How Can Future Accidents Be Prevented? (Mark all that apply)

Employee Training _____ Proper Use of Equipment _____ Improve Task Procedures _____ Improve Work Area _____
Equipment Correction _____ Removal of Hazard _____ Use of Personal Protective Equipment _____ Provide Hazard
Warning _____ Enforce Policy/Rule _____ Other _____ Explain: _____

Administrator/Supervisor Name

Signature

Date