STATE OF ALABAMA

Public Education Employee Injury Compensation Board (PEEICB)

ACCIDENT REPORT EMPLOYEE STATEMENT

Health Insurance Coverage: ☐ PEEHIP ☐ VIVA ☐ Other _____

Date of Injury/Accident	Today's Date:	Time of Injury/Accident: ☐ a.m. ☐p.m. On break or at lunch at the time of accident? ☐ Yes ☐ No
Employee Name (Last, First, Middle Initial)	Date of Birth:	Social Security Number (Complete SSN not just the last 4).

Street Address:	City:	State: Zip:
Primary Phone Number	Email Address:	

Employment Status: ☐Full Time ☐ Part Time ☐Adult Bus Driver

Preferred method of contact by PEEICB: (choose one) ☐Email ☐ U.S. Postal Service Mail Delivery ☐ By Telephone

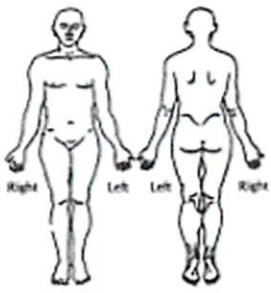
Job Title:	Name of Supervisor:	Date Supervisor Notified:

Describe the specific activity you were performing at the time the injury/accident occurred including exactly what happened to cause injury/accident.

Accident:

Injury/Body Part(s):

Exact location where injury/accident occurred:



Circle Injured Body Part

Were there any witnesses? ☐ Yes ☐ No If yes, give names, addresses and phone numbers of each:

At the time of injury/accident, were you using any protective equipment (ex. Latex gloves, eye protection)?
If yes, list equipment used.

Have you previously had pain, treatment, diagnostic testing (x-rays, MRI, etc.) or injury to the same body part? ☐ Yes ☐ No
If yes, enter body part affected, date(s) of injuries and name(s) and address(es) of treatment provider(s).

Was injury/accident a result of an automobile accident? ☐ Yes ☐ No
If yes, obtain a copy of the police report of the accident and submit it to your supervisor as soon as possible.

I understand the intentional reporting of false information may disqualify me from receiving further PEEICB benefits and could expose me to penalties or criminal charges. I certify all information is correct to the best of my knowledge. I further understand that non-compliance with PEEICB Rules (i.e. failure to attend medical appointments as scheduled, failure to respond to requests for contact, failure to provide signed medical authorization forms, failure to cooperate with PEEICB staff, failure to comply with my physician's medical treatment plan, etc.) may progressively lead to suspension and/or termination.

Signature of Employee: Date: Daytime Phone:

Signature of supervisor reporting incident: Date: Daytime Phone:

Email the completed form to:

1. **PEEICB@mrm-llc.com;**
2. **pcain@enterpriseschools.net; and**
3. **ecrowell@enterpriseschools.net**