

WORKERS' COMPENSATION REPORT

EMPLOYEE/SUPERVISOR/WITNESS

Note to Employee: All areas of this report must be completed. Otherwise, it will be returned to you and delay the processing of your claim.

If you are unable to return to work because of your injury, you MUST contact the Business Office by the following business day. Failure to do so could jeopardize your claim.

Name	Soc. Sec. #	Date of Accident	Date of Hire	Date of Birth
Address:				
Number	Street	Apt.#	City	State Zip Code
Phone Number (Include area code)		Accident Reported to: Title:		
Building where Injured:		Other Employer(s):		
School District:		Address:		
Contact: _____		Position:		
Describe Accident/Injury:				
Have you returned to work? (circle one) YES NO If YES, when?				
Date of first treatment: _____		List prior injuries or conditions:		
Are you still under treatment? (circle one) YES NO				
Medical treatment was received from: _____				
Employee Signature:			Date:	
WITNESS' REPORT				
Witness Name: (Please Print) _____				
To the best of my knowledge, this accident occurred as reported by the claimant. (Circle one)			YES	NO
If you are unable to confirm the claimant's version of the accident, please explain why:				
Witness' Signature:			Date:	
SUPERVISOR'S REPORT				
Supervisor's Name: (Please Print) _____				
This employee reported the above incident to me on: _____				
To the best of my knowledge, this accident occurred as reported by the claimant. (Circle one)			YES	NO
If you are unable to confirm the claimant's version of the accident, please explain why:				
List recommendations to prevent recurrence:				
Supervisor's Signature:			Date:	