

EMPLOYEE'S REPORT OF INCIDENT AND INJURY

PLEASE PRINT IN INK (to be completed by employee)

Locaton of Injury/Incident: _____

Name _____	Social Sec. No (last 4) _____
Home Address _____	Birth Date _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
City/State/Zip _____	Telephone: () _____

Date of injury or onset of symptoms _____ Time _____ am pm

Describe what caused the injury/symptoms, what you were doing, just before the incident, and what you did after the incident (if you need more space, write on the back of this form) Be specific - name any ojects or substances involved:

Did anyone see you get hurt? Yes No If yes, who? _____

Did you report this incident to anyone? Yes No If not, why not? _____

If yes, to whom did you report it? _____ Title/Position _____ When? _____

What part(s) of your body was/were affected? (BE SPECIFIC: for example, right elbow, left knee, right index finger):

What type of injury did you experience? (BE SPECIFIC: for example, bruise, scrape, lacertaion, pull) _____

Was any first aid provided at the scene? Yes No If yes, describe: _____

Did you seek aid provided at the scene? Yes No If yes, when _____

Where? _____ If treatment was not sought immediately, explain why: _____

Is this an aggravation of a previous injury/symptom? Yes No

If yes, when were you last treated for the previous injury? _____

By whom or where? _____

Have you ever had a similar injury? Yes No If yes, describe other injury: _____

MEDICAL RELEASE

Under current workers' compensation law, the employer is entitled to a signed medical release. I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kindw hich may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to **disclose such information** to my employer, my employer's managed care organization, or to my employer's designated representative, **Comp Management, Inc.** A copy of this form will serve as the original.

Employee Name (print) _____

Employee Signature _____ Date (required) _____

Distribution list: Original to Treasurer's Office, Copy to Superintendent 's Office