Employee Injury and Illness Report

To be Completed by Employee

Case No. _____

Date of Injury ____/____/____ (month / day / year)

TO BE COMPLETED BY EMPLOYEE

Social Security #	Name (Last) (First) (MI)	Sex (M or F)	Marital Status: r Married r Single r Divorced r Widowed

Home Address	City	State	Zip	Home #	Work #

Date of Birth ____/____/____ (month / day / year)	Age	Occupation	Department	Work Location and Title

Work Status: r Full time r Part time — Hours per Day	# Days per week if part time	Immediate Supervisor

Injured body part / areas *(indicate left or right if applicable)*	District building where accident occurred *(street, city, zip code)*

Time of Day injury or accident occurred: ____:____ AM or ____:____ PM	Date employer advised: ____/____/____ (month / day / year)

Is this a recurrence of a previous injury or illness? r Yes r No If "YES" please give details _____

Employee's Statement

Please describe in detail how the injury occurred. Include what the situation was and any objects or tools involved:

How did the accident occur? *(Explain how it happened)* _____

Was or will medical care be provided other than by school nurse? r Yes r No If yes, please complete the following:

Doctor's Name *School Nurse's Name* *Emergency Room Location*

Doctor's Address *School* *Hospital*

Were there any witnesses to the accident? r Yes r No If yes, please complete the following:

Witness Name: _____ Was the witness a District employee? r Yes r No Witness Phone #: _____

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If witness is not a District employee, please provide name and address: _____

_____ *Employee Signature*

____/____/____ *Date*

"Any person who knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, self-insurer or purported insurer, or any agent thereof, any written statement as part of or in support of a claim for benefits containing any false, incomplete, or misleading information commits a fraudulent insurance act."

EMPLOYEE INJURY AND ILLNESS REPORT

Employee Name_____ **Date of Injury or Illness**____/____/____

Supervisor's Investigation / Report: *This section must be completed by the supervisor prior to signing.*

TO BE COMPLETED BY SUPERVISOR

1. Cause Analysis: *Describe the factors contributing to this incident.*

2. Work Status: *Is the employee missing time from work:* r Yes r No r Don'tKnow

   If Yes, how much time has employee missed? _____

3. Recommended Corrective Actions: *What actions can / will be taken to prevent recurrence of this incident?*

_____ ____/____/____
Supervisor's Signature *Date*

Instructions

- *The lead secretary/building designee is to file an electronic injury report with the District's Workers' Compensation TPA-PMA Management Corp. and provide a hard copy to the employee's supervisor for follow up, documentation, and signature.*
- *Page 2 of this report needs to be completed by the employee's immediate supervisor.*
- *The original completed form must be sent to Risk Management, Central Office.*
- *The supervisor is to follow up on the recommended corrective actions.*

Claims can be reported at www.pmacompanies.com. Click on "Report a Claim".
The user ID will be your account # and the password is "newclaim".