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: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Home Address	City	State	Zip	Home #	Work #

Date of Birth_____/_____/_____ (month day year)	Age	Occupation	Department	Work Location and Title

Work Status: ☐ Full time ☐ 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? ☐ Yes ☐ 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)* ____________________

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

Witness Name:____________________ Was the witness a District employee? ☐ Yes ☐ No Witness Phone #:__________

Witness Name:____________________ Was the witness a District employee? ☐ Yes ☐ No Witness Phone #:__________

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."

7/15 CMC

Contact person: Lydia VanEvera 518-234-4032 ext 2000