

Employee Injury and Illness Report

To be Completed by Employee

Case No. _____

Date of Injury ____/____/____
month day year

Social Security #	Name (Last) (First) (MI)	Sex (M or F)	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Home Address	City	State	Zip	Home #	Work #
Date of Birth ____/____/____ month day year	Age	Occupation	Department	Work Location and Title	
Work Status: <input type="checkbox"/> Full time <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? ☐ 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."

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: ☐ Yes ☐ No ☐ Don't Know

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".