CENTRAL CITY PUBLIC SCHOOLS

(Completed by Injured Employee)

WORKERS' COMPENSATION INCIDENT REPORT

Print Employee's Name: ______________________________ Today's Date: ___________________

Phone# ____________Building Location: _________________ Supervisor: ________________________

INCIDENT INFORMATION

Date of Injury: ______________ Time ___________ ___am ___ pm Date Reported ______________

To whom reported? ____________________Did you miss time from work for the injury? ___Yes ___ No

If yes, give dates and times: ____

Returned to work? ____Yes ____ No _____Full Duty _____Light Duty

If no, date expected to return?_______________

What part of your body was injured? (Right leg, left arm)____

What is the injury? (Cut, Sprain, Bruise) ____

____

Explain in detail how the injury occurred: ____

____

____

Where did the injury occur? (Physical location)____

____

Any witnesses? ____Yes ____ No ***If yes***, give names: ____

____

Did you seek medical treatment? _____Yes _____No

If yes, give date & time: ______________________________

Doctor's name:__________________________________ Return visit date: ___________________________

What type of treatment are you getting? ____

How are you getting along now? ____

Have you ever injured this part of your body before? _____Yes _____No

If yes, explain when, how, and to what extent:
____

What would you do to prevent this from happening again? ____

____

Signature of Employee:_______________________ Print Employee's Name____________________