# EMPLOYEE'S REPORT OF INJURY

## PERSONAL INFORMATION

NAME | CLAIM #

ADDRESS | HOME PHONE | CELL PHONE

Gender: ☐ MALE ☐ FEMALE

N/A

DATE OF BIRTH | SOCIAL SECURITY NUMBER

OCCUPATION | EMPLOYER | DEPARTMENT

EMPLOYER ADDRESS

NUMBER OF DAYS PER WEEK | NUMBER OF HOURS PER DAY | NORMAL DAYS OFF

LENGTH OF EMPLOYMENT | WAGES (HOURLY RATE OF PAY)

## INJURY INFORMATION

DATE OF INJURY | TIME | DATE INJURY REPORTED

Accident reported to: _____ By (name): _____

Who witnessed accident (name & address for each person listed)? _____

Describe fully how injury happened (continue on back if necessary): _____

What part(s) of your body was injured? _____

Did you stop work as a result of your accident? ☐ YES ☐ NO When: _____

Was your pay continued during any part of your disability? ☐ YES ☐ NO

If so, for what period? _____ Last day for which you were paid? _____

If not working, date you expect to return to work? _____ If you did return to work, list date? _____

From whom did you receive first medical treatment (list date)? _____

Are you still under medical treatment? _____ How often do you receive treatment? _____

NAME OF DOCTOR | ADDRESS | PHONE

## SIGNATURE

SIGNATURE | DATE | CLAIM #

# SUPERVISOR'S REPORT OF ACCIDENT

## SCHOOL DISTRICT INFORMATION

Fruitport Community Schools
NAME OF SCHOOL DISTRICT

3255 E. Pontaluna Rd. Fruitport, MI 49415
MAILING ADDRESS

DIVISION | LOCATION | 231-865-3156 PHONE

## EMPLOYEE INFORMATION

EMPLOYEE'S NAME: FIRST, MIDDLE, LAST

HOME ADDRESS

HOME PHONE | CELL PHONE

DATE OF BIRTH | ☐ MALE ☐ FEMALE GENDER | N/A SOCIAL SECURITY NUMBER

OCCUPATION | DEPARTMENT

## ACCIDENT INFORMATION

DATE OF ACCIDENT | TIME OF ACCIDENT ☐ A.M. ☐ P.M. | REGULAR WORK?

Describe injury: _____

Body part injured: _____

Witness info: _____

Fatality? ☐ YES ☐ NO

How did the accident happen? _____

Employment date: _____ How long on this job? _____

Detail all machine or equipment involved: _____

Specify activity employee was engaged in when accident occurred: _____

What safety words or safety equipment was in place? _____

What should be done to prevent repetition? _____

Has it been done? ☐ YES ☐ NO If not, give reason: _____

NAME OF PHYSICIAN | ADDRESS

NAME OF HOSPITAL | ADDRESS

## SIGNATURES

SUPERVISOR'S SIGNATURE | DATE

REVIEWED BY | DATE