EMPLOYEE'S REPORT OF WORK RELATED INJURY
PIKE COUNTY SCHOOL SYSTEM

Employee should complete this form as soon as possible after an incident. ALL questions should be answered.

EMPLOYEE NAME____SS#____________________________________

POSITION__________________________BOE LOCATION______________________ NORMAL WORK HOURS ________TO _________

BIRTHDATE_________________________AGE_________SEX________HOME PHONE NUMBER ( ) ________________________

ADDRESS____
STREET CITY STATE ZIP

DID YOU HAVE AN INJURY BY ACCIDENT WHILE WORKING FOR THE PIKE COUNTY SCHOOL SYSTEM?______________

DATE OF INJURY_______________TIME_________AM/PM PLACE OF INJURY____

WHAT PART OF YOUR BODY WAS INJURED? (RIGHT HAND, LEFT FOOT, ETC.)____

WHAT TYPE OF INJURY? (BURN, SPRAIN, BROKEN BONE, ETC.)____

STATE WHAT YOU WERE DOING AT TIME OF ACCIDENT? (BE SPECIFIC)____

____

HOW DID ACCIDENT OR EXPOSURE OCCUR? (DESCRIBE CONTRIBUTING EVENTS, CONDITIONS, OR PERSONAL ACTIONS;

HOW AND WHY DID ACCIDENT OCCUR; HOW COULD THIS HAVE BEEN PREVENTED?)____________________________________

____

____

WHO WAS INJURY REPORTED TO____DATE REPORTED_______________________

WHO SAW THE ACCIDENT HAPPEN?____

DID YOU LEAVE WORK AS A RESULT OF THE INJURY? YES_______NO_______TIME LEFT WORK__________________________

DID YOU SEEK MEDICAL AID? YES_______NO_______

NAME AND ADDRESS OF TREATING PHYSICIAN ____

____

____

IF MEDICAL TREATMENT IS REQUIRED, PLEASE LIST ALL MEDICATIONS THAT YOU ARE TAKING (PRIOR TO INJURY)

____

ARE YOU EMPLOYED WITH ANY EMPLOYER OTHER THAN PIKE COUNTY SCHOOL SYSTEM? ______________

IF SO, NAME OF EMPLOYER AND POSITION HELD____

EMPLOYEE SIGNATURE____DATE_____________________________

SUPERVISOR SIGNATURE____DATE_____________________________

ANY ADDITIONAL INFORMATION, WHICH IS PERTINENT TO THIS CLAIM, SHOULD BE ATTACHED.

SUPERVISOR'S REPORT OF WORK RELATED INJURY

PIKE COUNTY SCHOOL SYSTEM

A Supervisor should investigate the incident thoroughly and as quickly as possible and answer ALL of the following questions.

EMPLOYEE______________________________________SS#________________________SALARY_______________HOUR/MONTH

OCCUPATION___________________________BOE LOCATION____________________DATE HIRED__________________________

BIRTHDATE___________________________AGE___________SEX_______ HOME PHONE # _______________________________

ADDRESS____
STREET CITY STATE ZIP

HOURS WORKED PER DAY______________________NORMAL WORK HOURS___________TO___________

DATE OF INJURY_______________________TIME__________AM/PM PLACE OF INJURY________________________________

WHO WAS INJURY REPORTED TO____DATE REPORTED_________________________

LIST ALL WITNESSES TO INCIDENT____

WHAT PART OF THE BODY WAS INJURED? (RIGHT HAND, LEFT FOOT, ETC)____

WHAT TYPE OF INJURY? (BURN, SPRAIN, BROKEN BONE, ETC.)____

WHAT WAS EMPLOYEE DOING AT TIME OF ACCIDENT? (BE SPECIFIC)____

____

HOW AND WHY DID ACCIDENT OR EXPOSURE OCCUR? (DESCRIBE CONTRIBUTING EVENTS, CONDITIONS, OR PERSONAL ACTIONS; HOW COULD THIS HAVE BEEN PREVENTED?)____

____

____

DID THE EMPLOYEE SEEK MEDICAL TREATMENT? YES______NO______

NAME AND ADDRESS OF TREATING PHYSICIAN ____

____

WAS EMERGENCY CARE REQUIRED? YES______NO______ IF YES, NAME OF HOSPITAL________________________________

WAS AMBULANCE REQUIRED? YES______NO______

DID EMPLOYEE LEAVE WORK AS A RESULT OF THE INJURY? YES_______NO_______TIME LEFT WORK__________________

DID EMPLOYEE WORK THE NEXT DAY FOLLOWING INJURY? YES_______NO_______FIRST DATE EMPLOYEE FAILED TO

WORK A FULL DAY______________________________IF RETURNED TO WORK, DATE___________________________________

SIGNATURE OF REPORTING SUPERVISOR____DATE________________________

SIGNATURE OF PRINCIPAL/DIRECTOR____DATE________________________

NOTE: NOTIFY PATTI MORRISON IN HUMAN RESOURCES, CENTRAL OFFICE OF INJURY IMMEDIATELY (EITHER BY PHONE AT 770-567-8489 OR E-MAIL AT MORRISP@PIKE.K12.GA.US). FORWARD THE INJURY REPORT AS WELL AS ANY ADDITIONAL INFORMATION WHICH IS PERTINENT TO THIS CLAIM TO CENTRAL OFFICE. IF THE EMPLOYEE HAS NOT RETURNED TO WORK AS OF THE DATE OF THIS REPORT, NOTIFY THIS OFFICE UPON HIS/HER RETURN.

WITNESS STATEMENT FOR WORK RELATED INJURY

PIKE COUNTY SCHOOL SYSTEM

NAME OF INJURED EMPLOYEE____

YOUR NAME ____PHONE #_____________________________

YOUR HOME ADDRESS____

STREET CITY STATE ZIP

BOE LOCATION____FOR HOW LONG? ____________________

HOW LONG HAVE YOU KNOW THE INJURED EMPLOYEE? _______________

HOW DID YOU COME TO KNOW HIM/HER? ____

HOW LONG HAVE YOU WORKED WITH HIM/HER? _______________________

WHEN DID THE INJURED EMPLOYEE STATE THE INCIDENT OCCURRED? __________________________

WHEN DID YOU FIRST BECOME AWARE OF THE INCIDENT? DATE __________________________TIME_______________________

DID YOU SEE THE INJURY OCCUR? YES_______NO_______

WHAT DID THE INJURED EMPLOYEE FIRST SAY TO YOU ABOUT THE INJURY? ____

____

WHAT PART OF THEIR BODY WAS INJURED? (RIGHT HAND, LEFT FOOT, ETC)____

WHAT TYPE OF INJURY? (BURN, SPRAIN, BROKEN BONE, ETC.)____

WHAT WAS EMPLOYEE DOING AT TIME OF ACCIDENT? (BE SPECIFIC)____

____

HOW AND WHY DID ACCIDENT OR EXPOSURE OCCUR? (DESCRIBE CONTRIBUTING EVENTS, CONDITIONS, OR PERSONAL ACTIONS____

____

____

HOW COULD THE INCIDENT HAVE BEEN PREVENTED?____

WAS THE INCIDENT REPORTED? __________ TO WHOM? ____

LIST ALL WITNESSES TO INCIDENT____

IN YOUR OPINION, DID THE INJURY POSSIBLY OCCUR OTHER THAN AS ALLEGED BY THE INJURED EMPLOYEE?___________

IF YES, PLEASE STATE WHY ____

ARE YOU AWARE OF PREVIOUS COMPLAINTS OF PHYSICAL PROBLEMS BY THE INJURED EMPLOYEE? ___________________

IF YES, PLEASE LIST____

PLEASE LIST ON THE BACK OF THIS FORM ANY OTHER INFORMATION YOU FEEL SHOULD BE CONSIDERED IN EVALUATING THIS CLAIM.

SIGNATURE OF WITNESS____DATE________________________

SIGNATURE OF SUPERVISOR____DATE________________________.