**WORKERS’ COMPENSATION**

**first report of injury and illness**

**Answer ALL questions. Sign, and give to your supervisor immediately. Please make and retain a copy for your records.**

|  |
| --- |
| **Section I:** **EMPLOYEE INFORMATION**  |
| **Last Name** | **First Name** | **Middle Initial** |
| **Telephone Number** | **Date of Birth** | **Age** | **Gender**[ ]  M [ ]  F | **Social Security Number** | **Average Weekly Salary** |
| **Address** | **City** | **State** | **Zip Code** |
| **Occupation/Title** | **Date of Hire** | **Work Status**[ ]  full-time [ ]  part-time | **Hours/day** | **Hours/week** | **Department** |
| **School Building / Location Accident Occurred (Street, City, Zip Code)** | **Immediate Supervisor** |
| **Section II: EMPLOYEE MEDICAL INFORMATION****Medical Treatment Received? [ ]  Y [ ]  N (*If no medical treatment, proceed to Section III)***  |
| *\*\*\*\*Should the injured employee receive medical treatment after the initial incident report, the employee can contact PMA at 1-888-476-2669.* |
| **Any Lost Time** [ ]  Y [ ]  N | **If yes, date disability began** | **If out of work: will salary be continued** |
| **Name of Attending Physician**  | **Inpatient Hospitalization** |
| **Address of Attending Physician** | **Name of Hospital** |
| **City State Zip Code** | **City State Zip Code** |
|  |
| **Section III: INCIDENT INFORMATION (*Please complete the entire section)*** |
| **Date of Injury or Illness: (Month/Day/Year)** | **Time of Injury/ Illness** | **[ ]  AM [ ]  PM** |
| **Is This a Recurrence of a Previous Injury or Illness****[ ]  Yes [ ]  No** |
| **If “Yes” Please Give Details (i.e., date of previous Injury and provide details)** |
| **Describe Part (s) of Body Injured/Nature of Occupational Illness (i.e., left arm, right foot, head, multiple, etc.)** |
| **Nature of Injury / Illness (i.e., laceration, burns, fracture, strain, etc.)** |
| **Cause of Injury / Illness (motor vehicle, machine, strain, or injury by lifting, etc.)** |
| **Injury/Occupational Illness Description** |
| **If Employee Unavailable for Signature, Explain Circumstances in this Space and Enter Incident** |

***OVER →***

**WORKERS’ COMPENSATION**

**first report of injury and illness**

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  **Employee Signature** |  |  **Date** |

|  |
| --- |
| **SECTION IV: WITNESS(ES)** |

 **[ ]  Yes [ ]  No**

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  **Name (please print)** |  |  **Phone #** |

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  **Name (please print)** |  |  **Phone #** |

|  |
| --- |
| **SECTION V: SUPERVISOR INFORMATION** |
| **Date Supervisor Notified: (Month/Day/Year)** | **Time Supervisor Notified:****[ ]  AM [ ]  PM** |  |

|  |  |
| --- | --- |
|  |  |
|  **Principal/Supervisor Name (please print)** |  |

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  **Principal/Supervisor Signature** |  |  **Date** |

**BY SIGNING THIS FORM, YOU ARE AFFIRMING THAT ALL INFORMATION PROVIDED BY YOU IS TRUE. PLEASE NOTE THAT KNOWINGLY MAKING A FALSE STATEMENT IN CONNECTION WITH AN APPLICATION FOR WORKERS’ COMPENSATION OR DISABILITY BENEFITS IS A CRIME. ANY PERSON KNOWINGLY MAKING A FALSE STATEMENT IN CONNECTION WITH THIS APPLICATION MAY BE SUBJECT TO CRIMINAL PROSECUTION THAT COULD RESULT IN FINES AND/OR IMPRISONMENT.**