**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.**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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**

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

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

**Yes  No**

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

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

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

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

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| --- | --- | --- |
|  |  |  |
| **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.**