BESSEMER CITY SCHOOLS
Injury Report Form

Name of Injured Employee	Social Security Number _____ - _____ -_____	Date of Birth ___/___/___	Sex M or F ____
Home Address	Telephone Number Home _____ Work _____	Job Title	Status
Employing Agency	Agency Address		
Date of Injury	Time of Injury	Date Employer Notified	
Is employee covered by medical insurance? If yes, please list:	Name and address of attending physician		
Name and address of medical facility where treated: ____ Hospitalized _____ Outpatient ____ Emergency Treatment	City or town where injury occurred		
Describe fully what happened to cause the injury or illness.			
Describe the injury or illness in detail and indicate the body part(s) affected.			
Were there any witnesses to the injury? ___ Yes ___ No (If yes, give name, address, and telephone number)			
Signature of Injured Person:_____ Date:_____ Print Name: _____ Telephone Number:_____			
Signature of Supervisor:_____ Date: _____ Print Name: _____ Telephone Number: _____			