FRANKLIN COUNTY SCHOOL SYSTEM
REPORT OF WORK RELATED INJURY

EMPLOYEE _____ SS # _____

OCCUPATION _____ LOCATION _____ DATE HIRED _____

BIRTHDATE _____ AGE _____ SEX _____ HOURS WORKED PER DAY _____

DATE OF INJURY _____ TIME _____ AM/PM PLACE OF INJURY _____

WHO WAS INJURY REPORTED TO _____ DATE REPORTED _____

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

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

_____

HOW DID THE ACCIDENT OR EXPOSURE OCCUR? (DESCRIBE CONTRIBUTING EVENTS, CONDITIONS, OR PERSONAL ACTIONS: HOW AND WHY DID THE ACCIDENT OCCUR?)

_____

_____

_____

DID EMPLOYEE LEAVE WORK AS A RESULT OF THE INJURY? YES/NO TIME LEFT WORK AM/PM

DID EMPLOYEE WORK THE NEXT DAY FOLLOWING INJURY? YES/NO FIRST DAY EMPLOYEE FAILED TO

WORK A FULL DAY _____ RETURNED TO WORK DATE _____

DID YOUR AUTHORIZE THE EMPLOYEE TO SEEK MEDICAL AID? YES/NO

NAME AND ADDRESS OF TREATING PHYSICIAN _____

_____

PHONE # _____ _____

HAS EMPLOYEE BEEN HOSPITALIZED? YES/NO IF YES, NAME OF HOSPITAL _____

HOME ADDRESS OF THE EMPLOYEE _____

_____

_____

HOME PHONE # _____

NOTE: NOTIFY CENTRAL OFFICE ADMINISTRATION OF INJURY IMMEDIATELY BY PHONE OR FAX. SUBMIT THIS REPORT WITHIN 24 HOURS. IF THE EMPLOYEE HAS NOT RETURNED TO WORK AS OF THE DATE OF THIS REPORT, NOTIFY CENTRAL OFFICE ADMINISTRATION UPON HIS/HER RETURN. ANY FURTHER INFORMATION, WHICH IS PERTINENT TO THIS CLAIM, SHOULD BE FORWARDED TO CENTRAL OFFICE ADMINISTRATION.

SIGNATURE OF W.C. DESIGNEE _____ **DATE** _____