Mobile County PUBLIC SCHOOLS

HS 002 (REV. 6/14)

MCPSS EMPLOYEE REPORT OF INJURY/ACCIDENT FORM

Complete this form immediately for all accidents reported by employees acting within the line and scope of employment

1. Name of Injured Employee (please type or print) (Last) (First) (MI)	2. Social Security Number	3. Date of Birth	4. Sex _____M _____F
5. Home Address Work: Years on Present Job _____	6. Telephone Number Home Alternate	7. Job Title Years Employed___ ____Contract (Y/N)	8. Status ____Full Time ____Part Time/Sub
9. School/Department	10. Agency Address: MOBILE COUNTY PUBLIC SCHOOL SYSTEM P O Box 180069 Mobile, AL 36618		
11. Date of Injury / 12. Time of Injury	13. Date & Time Supervisor Notified	Did Employee continue to work at assigned tasks after accident ___ Y ___ N	
14. Is employee covered by medical insurance? ____ Y ____ N If yes: _____ Blue Cross/Blue Shield _____ Other Insurance Name of Insurance Carrier:_____	15. Name and address of attending Physician		
16. Name and address of medical facility where treated ____ Hospitalized ____ Outpatient ____ Emergency Treatment	17. City or town where injury occurred	18. Location/place where injured. School/Dept., Be specific, i.e, which classroom, office, where on grounds, etc.	

19. Did Employee seek medical treatment: Immediately During Work Hours After Work Hours

20. Describe fully what happened to cause the injury or illness:

21. Describe the injury or illness in detail and indicate the body part(s) affected:

22. 1 ST Aide/Treatment Employee received:

23. Were there any witnesses to the injury? _____Yes _____ No (If "yes", give name, address, and telephone number)

24.

Signature of Injured person	Print Name	Daytime Telephone Number	Date
_____	_____	_____	_____

25. INVESTIGATION OF THE ACCIDENT: TO BE FILLED OUT BY THE ADMINISTRATOR/SUPERVISOR ONLY (Attach additional sheets if needed)
How did the accident happen? What was the employee doing?

Signature of Supervisor	Print Name	Daytime Telephone Number	Date
_____	_____	_____	_____

For Central Office Use Only : Employee Paid For: _____ hrs/days Days Used _____ Date Returned to Work Full Status

LEAIR FORM 1 adapted for MCPSS