Mississippi School Boards Association

WC Trust

A Workers' Compensation Program

msba

WORKERS COMPENSATION
FIRST NOTICE OF LOSS

EMPLOYEE

First Name _____

Middle Initial _____

Last Name _____

ADDRESS

and Street _____

City _____

State _____

Zip Code _____

Phone # _____

Date of Birth _____

Social Security# _____

EMPLOYEE INFO

Gender (check one):

Male _____ Female _____ Unknown _____

Date hired _____

Occupation/Job Title _____

Employment Status (check one):

Full Time _____ Part Time _____ Temporary _____

WAGE (To be completed by Central Office)

Rate (check one):

Day _____ Week_____ Month _____ Other _____

Did salary continue? (check one):

Yes _____ No _____

OCCURRENCE

Date of Occurrence _____

Time Employee Began Work:

_____ A.M. _____ P.M.

Time of Occurrence:

_____ A.M. _____ P.M.

Last Day Worked _____

Date Employer Notified _____

Date Disability Began (if applicable) _____

CONTACT PERSON

Local School:

First Name _____

Last Name _____

Phone # _____

Type of Injury/Illness _____

_____

Nature of Injury _____

_____

Part of Body Affected _____

_____

Did Injury/Illness occur on Employer's premises? (check one)

Yes _____ **No** _____

Department or location where accident or illness occurred.

_____

_____

_____

All equipment, materials, or chemicals Employee was using when accident or illness occurred.

_____

_____

_____

Specific activity the Employee was engaged in when the accident or illness occurred.

_____

_____

_____

Work process the Employee was engaged in when the accident or illness occurred.

_____

_____

_____

Cause of Injury/Illness _____

_____

_____

Date Returned to work _____

If Fatal, Give Date of Death _____

Were safeguard or safety equipment provided? (check one):

Yes _____ **No** _____

Were safeguards used? (check one):

Yes _____ **No** _____

TREATMENT

Healthcare Provider:

Name & Address _____

_____

_____

Hospital:

Name & Address _____

_____

_____

OTHER

Witness:

First Name _____

Last Name _____

Phone # _____

Date Administer Notified _____

Date Prepared _____

ADDITIONAL NOTES

_____

_____

_____

_____

_____