BESSEMER CITY SCHOOL SYSTEM

Injury Report Form

Name of Injured Employee	**Social Security Number** _____ - ____ - ______	**Date of Birth** ___/___/____	**Sex** M or F Circle 1
Home Address	**Telephone Number** Home: _________________ Work: __________________	**Job Title**	**Status**
Employing Agency	**Agency Address**		
Date of Injury	**Time of Injury**	**Date Employer was Notified**	
Is employee covered by medical insurance? If yes, please list provider:		**Name & Address of attending physician**	
Name & address of medical facility where treated: _______ Hospitalized ______ Outpatient _______ Emergency Treatment		**City or Town where injury occurred**	
Provide full description on incident to cause 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, provide name, address, and telephone number			
Signature of Injured Person: ________________________ **Date :** ____________________ **Print Name :** __________________________________ **Telephone Number:** _________________			
Signature of Supervisor : ___________________________ **Date :** ____________________ **Print Name :** __________________________________ **Telephone Number:** _________________			
Signature of Superintendent : ___________________________ **Date :** _________________			

Effective 2-1-2021