EMPLOYEE'S REPORT OF INJURY

FULL NAME____DATE___________________________

HOME ADDRESS____

HOME PHONE___________________________ BIRTHDATE___________________AGE______________

S S #_________________________WORK LOCATION______________________HOW LONG___________

WORK HOURS: FROM_______TO_______ JOB TITLE________________DUTIES____________________

DID YOU HAVE AN INJURY BY ACCIDENT WHILE WORKING FOR THE MILLER COUNTY SCHOOL SYSTEM? YES OR NO

DATE OF INJURY________________________________TIME____________________________AM OR PM

DID YOU SEEK MEDICAL HELP? ______________WHICH DOCTOR______________________________

LIST ALL PART (S) OF YOUR BODY THAT WERE INJURED. PLEASE BE SPECIFIC ______________

____

WHERE DID THE ACCIDENT HAPPEN? ____

WHO SAW THE ACCIDENT HAPPEN? ____

TO PREVENT THIS TYPE OF ACCIDENT IN THE FUTURE, IN YOUR OPINION, HOW COULD THIS ACCIDENT HAVE BEEN PREVENTED? ____

IF THIS INJURY REQUIRES MEDICAL TREATMENT, PLEASE LIST ANY PRESCRIPTION DRUGS THAT YOU ARE PRESENTLY TAKING. ____

ARE YOU EMPLOYED WITH ANY OTHER EMPLOYER BESIDES THE MILLER COUNTY SCHOOL SYSTEM? __________ IF YES, WHERE ARE YOU EMPLOYED_____________________________________

HOW MANY DEPENDENTS DO YOU HAVE? (INCLUDING YOUR SPOUSE)_______________________

EMPLOYEE SIGNATURE_______________________________________DATE_______________________

SUPERVISOR/S SIGNATURE____________________________________DATE_______________________

FOR MILLER COUNTY SCHOOL SYSTEM OFFICE USE ONLY:

DATE RECEIVED______________________DATE WC1 FILED________________WC4________________

SUPERVISOR'S REPORT OF INJURY

PLEASE INVESTIGATE THE INCIDENT THOROUGHLY AND AS QUICKLY AS POSSIBLE AND ANSWER **ALL QUESTIONS**.

NAME OF INJURED_____________________________ DATE OF INJURY_____________________

SOCIAL SECURITY NUMBER____________________ SEX: ________MALE ________FEMALE

HOME ADDRESS_______________________________________ HOME PHONE ________________

CITY/STATE/ZIP _______________________________________ WORK PHONE ________________

JOB TITLE ______________________ HOURS WORKED PER DAY ______ PER WEEK _________

DID THE EMPLOYEE SEEK MEDICAL TREATMENT? ______ YES ______ NO IF YES, WHICH DOCTOR DID HE/SHE SEE? ____________________________

WAS EMERGENCY CARE REQUIRED? _______ YES _______ NO IF YES, WHAT FACILITY WAS USED? ____

WAS AN AMBULANCE REQUIRED? _______ YES ________ NO

WHAT TIME DID THE ACCIDENT OCCUR? __________ AM __________ PM

DID THE EMPLOYEE RETURN TO WORK? ________ YES ________ NO

IF YES, WHAT DATE? ________________

IF NO, WHAT WAS THE FIRST DATE THE EMPLOYEE DID NOT WORK? ___________________

AT WHAT LOCATION DID THE ACCIDENT OR INJURY OCCUR? __________________________

ON WHAT DATE DID YOU FIRST BECOME AWARE OF THE ACCIDENT? _________________

WHAT PART(S) OF THE EMPLOYEE'S BODY WAS AFFECTED? BE SPECIFIC. ______________

____

WHAT IS THE NATURE OF THE INJURY? (I.E. BURN, FRACTURE, STRAIN, CUT, ETC.) _____

____

HOW DID THE ACCIDENT OCCUR? NAME THE MACHINE, TOOL OR THING CAUSING THE INJURY AND STATE WHAT THE EMPLOYEE WAS DOING AT THE TIME OF THE INJURY. BE SPECIFIC AND USE THE BACK OF THIS FORM IF NECESSARY. (PLEASE DO NOT STATE THE ACCIDENT WAS UNAVOIDABLE. FOR SAFETY REASONS, WE NEED TO DETERMINE WHAT CAUSED THE ACCIDENT AND HOW TO PREVENT IT FROM OCCURRING IN THE FUTURE. FOR EXAMPLE, WAS IT A WET FLOOR, LOOSE CARPET, OBJECT ON STAIRS, NOT PAYING ATTENTION, HURRYING, ETC.)

WERE THERE ANY WITNESSES? ____ YES ____ NO IF YES, PLEASE NAME ______________

SIGNATURE OF SUPERVISOR __________________________________

SIGNATURE OF PRINCIPAL/DIRECTOR ________________________________

Miller County Board of Education

Vic Fleet. Board Chair
Rick Little. Vice-Chair
Shane Miller. Superintendent

Sheila Allen
Leroy Bush
Jarrott Mock

96 Perry Street
Colquitt. GA 39837

Phone: (229) 758-5592
Fax: (229) 758-3255

Date: ______________________________

Dear ______________________________,

Our employee, ____ , has sustained an injury/illness on the job. Please provide the necessary treatment, and forward your billing information to Georgia Administrative Services, 1775 Spectrum Drive, Suite 100, Lawrenceville, GA 30043.

Thank you.

Miller County Board of Education

BY: ______________________________
Supervisor/Principal

____
Department/School

TO BE COMPLETED BY INJURED EMPLOYEE:

I agree that if my apparent on-the-job injury/illness later proves to be non-related to my employment, I will know that I am responsible for any resulting medical expenses.

______________________________ ______________________________
Date Signature

ONE COPY TO DOCTOR - ONE COPY TO CENTRAL OFFICE