WORKERS' COMPENSATION REPORT
EMPLOYEE/SUPERVISOR/WITNESS

Note to Employee: All areas of this report must be completed. Otherwise, it will be returned to you and delay the processing of your claim.

If you are unable to return to work because of your injury, you MUST contact the Business Office by the following business day. Failure to do so could jeopardize your claim.

Name	Soc. Sec. #	Date of Accident	Date of Hire	Date of Birth

Address:

Number **Street** **Apt. #** **City** **State** **Zip Code**

Phone Number (include area code)	**Accident Reported to:**
School District: Contact: ____________________	**Other Employer(s):** **Address:** **Position:**

Describe Accident/Injury:

Did you stop work due to accident/injury (Circle one) YES NO If YES, when?

Date of first treatment: ____

Are you still under treatment? (Circle one) YES NO

Medical treatment was received from: ____

Employee Signature: ___________________________________ **Date:** ________________________

WITNESS' REPORT

Witness' Name: (Please Print) ____

To the best of my knowledge, this accident occurred as reported by the claimant. (Circle one) YES NO

If you are unable to confirm the claimant's version of the accident, please explain why: __________________________

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Witness' Signature: ____ **Date:** _____________________

SUPERVISOR'S REPORT

Supervisor's Name: (Please print) ____

This employee reported the above incident to me on: ____

To the best of my knowledge, this accident occurred as reported by the claimant. (Circle one) YES NO

If you are unable to confirm the claimant's version of the accident, please explain why: __________________________

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Supervisor's Signature: ____ **Date:** _____________________