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:** **Title:**
Building where Injured: **School District:** **Contact:** _____	**Other Employer(s):** **Address:** **Position:**

Describe Accident/Injury:

Have you returned to work? (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:** _____	**List prior injuries or conditions:**

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:

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:

List recommendations to prevent recurrence:

Supervisor's Signature: **Date:**