Liberty-Benton Schools

First Report of Injury

(To be completed by the injured worker or supervisor and submitted to the Workers' Compensation Coordinator within 24 hours of injury)

Employee Information

Full Name: _____ SS#: _____ Date of Birth: _____

Home Mailing Address: _____ Work Phone: _____

City, State, Zip Code: _____ Home/Cell Phone: _____

Work Location: _____ Position: _____

Injury Information

Date of Injury: _____ Time of Injury: _____

Date and Time Reported: _____ To Whom: _____

Names of Witnesses: _____

Accident Location (be specific): _____

Detailed Description of How Injury Occurred (what happened before, during, and after the accident): _____

_____

_____

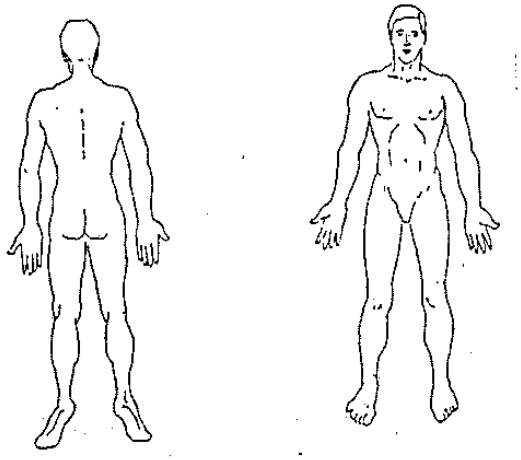
_____

Where specifically are you having pain? (List all affected areas) _____

_____

Have you ever injured this part of your body before? Yes_____ No_____

Circle on the diagram location of injury



_____
Employee Signature

Type of Injury (circle)

1. Strain/Sprain
2. Pain/Soreness
3. Laceration
4. Bruise
5. Pulled Muscle
6. Scratch/Abrasion
7. Burn
8. Swelling
9. Bite
10. Irritation
11. None apparent
12. Fracture
13. Other

Have you or do you plan to see a doctor regarding this problem? Yes_____ No_____

Treating Physician: _____ Phone: _____

Address: _____

Do you work anywhere other than Liberty-Benton Schools? Yes_____ No_____

If yes, where? _____

Signature: _____ Date Signed: _____

Please return this to the Workers' Compensation Coordinator. If medical treatment is sought, it is the employee's responsibility to provide copies of all medical documentation to the Workers' Compensation Coordinator. (Your doctor should provide you with a MEDCO-14 "Physician's Report of Work Ability" for return to work indicating what restrictions, if any, apply.) For questions call 419-425-3589.

Please fax this form to 419-425-3628 within 24 hours of injury.
Send copies of this form to Superintendent, Treasurer, and Supervisor.