Orig. Code_____ Claim#_____ Date Rec'd._____

Prince George's County Public Schools

Workers' Compensation – Report of Injury

This form must be completed on the day of the accident for all injuries no matter how minor. This form must be sent to the Risk Management Office. (Employee Section will be completed by Supervisor if employee is physically unable). A Workers' Compensation Attending Physician's Statement form must be submitted to the Risk Management Office for each doctor's appointment.

To Be Completed By Employee – PLEASE PRINT OR TYPE **Please answer all questions**

Name_____ EIN#_____ SS#_____

Address_____ _____

Home Phone_____Cell_____

□ Male □ Female □ Married □ Single □ Widowed □ Divorced

1. Date of Injury_____ School/Dept. Assigned_____ Work#_____

Occupation when injured_____ Place where accident occurred_____

Was this your regular occupation? ____YES_____NO

Day of Week_____ Time_____am or pm Time You Begin Work_____

2. Did you receive medical attention _____Yes _____No

Physician:_____ Address:_____

Hospital/Clinic:_____ Address:_____

3. Date disability began (first day out)_____

4. Date Supervisor informed of injury:_____ Supervisor's Name:_____

Witness to Injury:_____ Work Location:_____

5. **Describe in detail what you were doing when the accident/illness happened, how this accident/illness happened and the injury to the body and the part of the body that is injured (left leg, right knee, etc.)**

_____

_____

_____

_____

Employee's Signature_____Date_____

TO BE COMPLETED BY SUPERVISOR: (You are acknowledging that you were informed of incident only)

1. **Has employee been charged leave? ____Yes ____No**
2. **Has employee returned to work? ____ Yes ____No**
3. **Were safeguards or safety equipment provided and used? ____ Yes ____No _____NA**
4. **Was this a fatal accident? ____Yes ____No**

Signature of Principal/Supervisor:_____ Date_____