Employee Report of Incident

- **Injured employee MUST complete and sign page 1 and notify Employee Benefits within 24 hours of accident. 973-4579**
- **Supervisor MUST complete page 2, sign and then FAX completed form to the Worker's Compensation office. 973-4671**

Date: ______ **Base Location:** ______ **Department** ______ **Job Title** ______

Employee Name: ______ Employee ID#: ______ Birth Date: ______
Home Address: ______ City: ______ Zip: ______ Gender: M F
Date of injury: ______ Time of Incident: ______ A.M. / P.M. Where did the incident occur? ______

1. **Describe in detail the activity, operation and/or process being performed when the accident took place that directly caused your injury, and what you were doing when you were injured. Be specific: What happened? When did it happen? Where you were when it happened? How did it happen?** ______
2. **Describe in detail the nature and extent of your injury, and the specific the body part (s) affected.**
3. **Did anyone witness the incident?** ______ **If yes please have them complete the Witness Section on page 2 of this form.**
4. Have you ever had a prior injury or medical treatment to the specified body part(s)? ______
5. If yes, please describe in detail the prior injury and treatment received:
6. Who is your primary care physician? ______ Contact Information: ______
7. If you do not have a family physician who was the last physician you were seen by? ______
8. Have you ever received treatment from any other care providers for the specified body parts affected? If yes, please list:
9. How long have these current physical complaints been bothering you? ______
10. Have you been receiving any treatment for these symptoms / injury? If so please list specific treatment received.
11. Are you currently taking any prescription or over the counter medication for these symptoms / injury? If so please list medications. ______
12. Has your personal physician provided you with any treatment or therapy for these symptoms? If so please describe.
13. Are there any other physicians or health care providers that have seen or treated you for these symptoms? Please list.
14. ______
15. Do you have any other jobs outside the district? ______ If yes please list name of employer and contact information:
16. Do you have a gym membership or participate in any athletic activities or hobbies? If so please describe.
17. Do you have any personal health conditions such as diabetes, asthma, arthritis, high blood pressure, etc? If so please describe

"I, ______, certify that the above information is true and correct to the best of my knowledge. I understand that providing false information could subject to disciplinary action, up to and including termination, as well as civil and criminal penalties for providing false information in connection with seeking workers' compensation benefits. I further understand that misrepresentation to obtain benefits is punishable under federal law and that one could spend time in prison and /or pay restitution if convicted. I authorize the release of any and all protected health information (PHI), including but not limited to histories and physicals, progress notes, operative reports, laboratory reports, diagnostic testing, prescriptions, any and all information relating to my medical care and treatment from those health providers from which I have received any and all prior medical care ."

Employee's Signature ***Date***

Employee's Printed Name ***Date of Birth*** ***Home Phone Number***

Supervisor's Report

(To be filled out by the injured employee's supervisor and witness, if applicable)

WITNESS STATEMENT:

____
____
____
____
____
____
____

Witness printed name	*Witness Signature*	*Witness Contact Number*	*Date*

SUPERVISOR REPORT:

Describe any safety rules or procedures which pertain to the operation being performed, i.e. required personal protective equipment, machine guards, lockout/tagout, etc.: ______________________________________
____
____
____

Describe any measures which would have prevented this accident: ______________________________
____

Describe the actions you will take to see that this type of accident does not happen in the future:
____
____

Give the approximate date by which you anticipate all preventive actions will be in place: ____________________

Supervisor's comments (use a separate sheet if necessary): ______________________________
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____
____

Supervisors printed name	*Supervisor Signature*	*Contact Number*	*Date*

Fax the completed form immediately following the incident to 973-4671 or send to the
Employee Benefits and Insurance Management office, 903 S Edgemoor, Wichita, KS 67218.
If form is faxed KEEP the original for your files.
Any statements of expense or doctor's notes should be submitted, when available, to the same location.
If questions arise regarding this form please call the Worker's Compensation office at 973-4579