

**LAKE FENTON COMMUNITY SCHOOLS**

**EMPLOYEE'S REPORT OF INJURY**

Name \_\_\_\_\_ Claim # \_\_\_\_\_

Address \_\_\_\_\_

Occupation \_\_\_\_\_ Date of Birth \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Sex \_\_\_\_\_ Married or Single \_\_\_\_\_ Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

Department \_\_\_\_\_ No. days/week \_\_\_\_\_ Normal days off \_\_\_\_\_

Length of employment \_\_\_\_\_ Wages (hourly rate of pay) \_\_\_\_\_ Number hours worked/day \_\_\_\_\_

**COMPLETE THE FOLLOWING IF YOU HAVE DEPENDENT CHILDREN UNDER 21 YEARS OF AGE LIVING WITH YOU**

Name of Dependent Child	Age	Name of Dependent Child	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Name any dependent children not at least 50% supported by you. \_\_\_\_\_

Date of injury \_\_\_\_\_ Time \_\_\_\_\_ Date injury reported \_\_\_\_\_

Accident reported to \_\_\_\_\_ By (name) \_\_\_\_\_

Who witnessed accident? \_\_\_\_\_  
(Name & Address) \_\_\_\_\_

Describe fully how injury happened \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Continue on back if necessary)

What part(s) of your body were injured? \_\_\_\_\_

Did you stop work as a result of your accident? Yes  No  When? \_\_\_\_\_

Was your pay continued during any part of your disability? \_\_\_\_\_

If so, for what period? \_\_\_\_\_ Last day for which you were paid \_\_\_\_\_

If not working when do you expect to return to work? \_\_\_\_\_ If you did return what was the date? \_\_\_\_\_

From whom did you receive first medical treatment? \_\_\_\_\_ Date of treatment \_\_\_\_\_

Are you still under medical treatment? \_\_\_\_\_ How often do you receive treatment? \_\_\_\_\_

Name of doctor treating you \_\_\_\_\_

Address of doctor \_\_\_\_\_ Phone # \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Claim # \_\_\_\_\_