ACCIDENT INFORMATION

EMPLOYEE'S REPORT OF INJURY

ATTENTION EMPLOYEE: SDCL 62-4-51 provides that any person who knowingly files a fraudulent claim for workers' compensation benefits is guilty of a Class 1 misdemeanor.

Please call 877.337.2156 *PRIOR* to seeking any medical treatment

1. NAME OF SCHOOL DISTRICT:

2. NAME: LAST FIRST M.I.

3. WHAT HAPPENED? (If a diagram drawing helps, draw on the back of the form)

4. NAMES OF WITNESSES: (Persons present at the time of injury)

5. LOCATION OF ACCIDENT:

6. HOW WERE YOU HURT?

7. WHAT IS YOUR INJURY?

8. DATE OF INJURY: 9. TIME OF INJURY: _____A.M. _____P.M.

10. DID YOU SEEK MEDICAL ATTENTION? YES_____ NO _____

11. PHYSICIAN'S NAME, ADDRESSS, AND TELEPHONE: 12. HOSPITAL OR CLINIC NAME, ADDRESS AND TELEPHONE:

13. WHO ACCOMPANIED YOU TO THE HOSPITAL OR CLINIC?
NAME:

A SCHOOL DISTRICT EMPLOYEE? YES_____ NO _____

14. DATE REPORT RECEIVED AND NAME OF PERSON RECEIVING REPORT:

(When this form is sent to the ASBSD, it must be accompanied by the Employer's First Report of Injury)