

## SPRINGFIELD CITY SCHOOL DISTRICT WORKPLACE ACCIDENT REPORT

Name _____	Social Sec. No. _____
Home Address _____	Birth Date _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
City/State/Zip _____	Contact Telephone #: (      ) _____
Job Title _____	Date of Hire _____
Location of Accident _____	

Date of injury **or** onset of symptoms \_\_\_\_\_ Time \_\_\_\_\_  am  pm

Described what caused the injury/symptoms, what you were doing **just before** the incident, and what you did **after** the incident (if you need more space, write on the back of this form). **Be specific - name any objects or substances involved:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*Type of Injury. This section to be completed for all accidents.*

<input type="checkbox"/> Abrasion	<input type="checkbox"/> Concussion	<input type="checkbox"/> Strain/Sprain	<input type="checkbox"/> Fracture
<input type="checkbox"/> Bruise	<input type="checkbox"/> Cut	<input type="checkbox"/> Laceration	<input type="checkbox"/> Puncture
<input type="checkbox"/> Burn	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Other, specify: _____	

*Part of body involved. This section to be completed for all accidents. If Back Injury, also complete Back injury form*

left	right	left	right	left	right	left	right
<input type="checkbox"/> Chest	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/> Hip	<input type="checkbox"/>
<input type="checkbox"/> Back	<input type="checkbox"/>	<input type="checkbox"/> Teeth	<input type="checkbox"/>	<input type="checkbox"/> Upper arm	<input type="checkbox"/>	<input type="checkbox"/> Upper leg	<input type="checkbox"/>
<input type="checkbox"/> Abdomen	<input type="checkbox"/>	<input type="checkbox"/> Face	<input type="checkbox"/>	<input type="checkbox"/> Lower arm	<input type="checkbox"/>	<input type="checkbox"/> Lower leg	<input type="checkbox"/>
<input type="checkbox"/> Groin	<input type="checkbox"/>	<input type="checkbox"/> Eye	<input type="checkbox"/>	<input type="checkbox"/> Elbow	<input type="checkbox"/>	<input type="checkbox"/> Knee	<input type="checkbox"/>
<input type="checkbox"/> Ear	<input type="checkbox"/>	<input type="checkbox"/> Nose	<input type="checkbox"/>	<input type="checkbox"/> Scalp	<input type="checkbox"/>	<input type="checkbox"/> Toes	<input type="checkbox"/>
<input type="checkbox"/> Fingers	<input type="checkbox"/>	<input type="checkbox"/> Ankle	<input type="checkbox"/>	<input type="checkbox"/> Mouth	<input type="checkbox"/>	<input type="checkbox"/> Hand	<input type="checkbox"/>

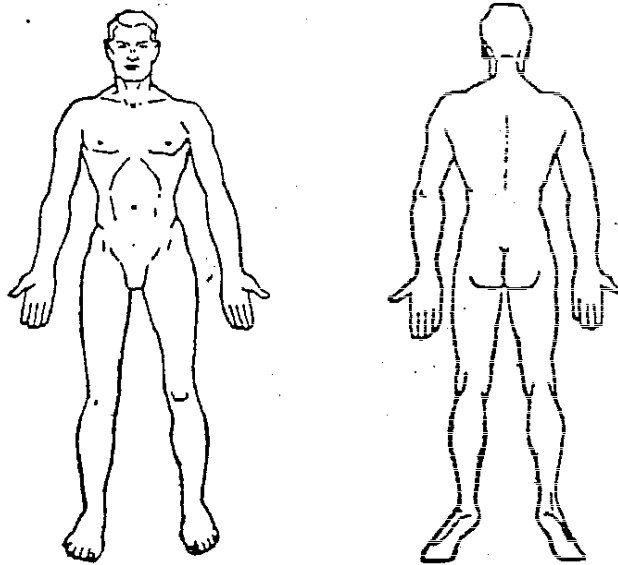
Additional Part of Body Description: \_\_\_\_\_

\_\_\_\_\_

*Cause of Incident. This section to be completed for all accidents.*

<input type="checkbox"/> Animal/Insect bite	<input type="checkbox"/> Collision with person	<input type="checkbox"/> Toxic substance	<input type="checkbox"/> Fighting
<input type="checkbox"/> Struck by vehicle	<input type="checkbox"/> Struck by object	<input type="checkbox"/> Collision with object	<input type="checkbox"/> Lifting
<input type="checkbox"/> Exposure to weather	<input type="checkbox"/> Exposure to blood	<input type="checkbox"/> Hot surface/substance	<input type="checkbox"/> Slip/trip/fall
<input type="checkbox"/> Other, specify: _____			

\_\_\_\_\_



Please color any injured body parts on these images

Did anyone see you get hurt?  Yes  No If yes, who? \_\_\_\_\_

Did you report this incident to anyone?  Yes  No If not, why not? \_\_\_\_\_

If yes, to whom did you report it? \_\_\_\_\_ Title/Position \_\_\_\_\_ When? \_\_\_\_\_

Was any first aid provided at the scene?  Yes  No If yes, describe: \_\_\_\_\_

Will you seek medical treatment from a licensed medical professional?  Yes  No If yes, when? \_\_\_\_\_

I have been provided a copy of SCSD workplace injury procedures and our Managed Care System (MCO) is CompManagement Health System and the BWC medical provider will submit all medical bills related to this workplace injury to CompManagement Health Systems, Inc. 1-888-247-7799  Yes  No

I certify that my statements are true and to the best of my knowledge.

Employee Name (print) \_\_\_\_\_

Employee Signature \_\_\_\_\_ Date (required) \_\_\_\_\_

**Medical Release**

*Under current workers' compensation provisions, the employer is entitled to a signed medical release*

I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to **disclose such information** to my employer, my employer's managed care organization, or to my employer's designated representative, **CompManagement, Inc.** A copy of this form will serve as the original.

Employee Name (print) \_\_\_\_\_

Employee Signature \_\_\_\_\_ Date (required) \_\_\_\_\_