GEORGE COUNTY SCHOOL DISTRICT

494 Cowart Street / Lucedale, MS 39452

ACCIDENT REPORTING FORM

DIRECTIONS: Any employee injured on school premises must complete this form and submit it to their school administrator for signature. After the administrator signs the form, it should be forwarded to the George County School District Human Resources Department.

Injury Information

*Date of loss/injury: _____ *Jurisdiction/State Injured Worker was hired : _____

Time of Injury_____

Injured Worker-Personal/Wage Information

*Injured Worker's name: _____

**Birth date: ____/____/_____ **Injured Worker's Social Security Number: _____-____-_____

**Injured Worker's mailing address: _____

**Hire date: ____/____/_____ Gender: _____ Marital status: _____ Primary Language_____

Job Title:_____

Employee Status (Full-time/Part-time)_____

**Injured Worker's phone # with area code: (____) _____

Injured Worker's Email_____ # of dependents: _____

**Days Worked Per Week _____ **Hours Worked Per Day_____

**Full Wages Paid for Date of Injury? (Yes/No/Unknown)_____ Did Salary continue?_____

*Location where injured worker reports to/works :_____

*Class Code: _____

Department (location code):_____ Sub Department_____

Occurrence -Accident Information

Last Day Worked: ____/____/_____ Employer first knowledge of Injury Date ____/____/_____

Claim Administrator First Knowledge of Injury Date ____/____/_____

Initial Date Disability Began ____/____/_____ Employer Knowledge of Disability Date ____/____/_____

Preexisting Disability? Y/N

*Nature of Injury:_____

*Part of Body Injured:_____

Part Injured Location (L/R/Bilateral):_____Finger/Toe:_____

Address where accident occurred: _____

Accident Site Narrative (any additional information):_____

*Accident/Injury Description:_____

*Cause of Injury (drop-down online): _____

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Injury Severity (drop-down online):_____

**Initial Return to Work Date:_____

Initial Return to Work Type:_____

Initial Return to Work Physical Restriction (Y/N):_____

Restrictions:_____

Initial Date of Lost Time:_____ Date of Death: _____

*Death Result of Injury (Y/N):_____

*Accident Result on Employer Premises (Employer/Lessee/Other):_____

Describe the events that caused the injury:_____

Object that directly injured the employee:_____

Activity the employee was engaged in when event occurred:_____

Additional comments about accident:_____

Witness Name and phone number (up to 3):_____

Supervisor Name and phone number:_____

Treatment Information

Provider:_____

Provider Address:_____

Provider Phone:_____

Hospital:_____

Hospital Phone:_____

*Initial Treatment (drop down online):_____

Follow-Up Treatment:_____

Was Panel Provided (Y/N)? _____

Hospital Address:_____

Contact Information

Preparer Name and email:_____

Preparer Work Phone:_____ *Is Preparer the contact (Y/N):_____

Contact Name:_____

Contact Phone:_____ Contact Email:_____

Contact Title:_____

Insured Comments:_____

Administrator's Signature_____