

Southern State Community College

Employee Injury Report Form

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Location

To be filled out by injured/ill employee

General Information

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|-------------------------------------|------------|-------------|-------------------------|
| Last Name | First Name | Middle Int. | Telephone Number () |
| Address (Number, Street, Apartment) | | | |
| City, State, ZIP Code | | | |

Claimant Data

| | | | |
|--------------------------|----------------|---|------------------------------|
| Date of Birth | Sex • M • F | Marital Status • Married • Single • Divorced • Widowed | S.S. Number |
| No. of Children Under 18 | Height | Weight | Rate of Pay per |
| | Education | | Work Telephone Number () |
| Work Address | | | |

Position & Job Description

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|------------------|--------------|-----------------------|
| Supervisor | Date of Hire | Days and Hours Worked |
| Other Employment | | Supervisor |
| Prior Employment | | Supervisor |

Description of Accident

| | | |
|------------------|----------------------|------------------|
| Date of Accident | Time • AM • PM | Location/Address |
| Description | | |
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Reported to Whom and When

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Witnesses (Name and Telephone Number)

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|-----------------------------|-------------------|----------|
| Police | City/County/State | Report # |
| Telephone # | | |
| Hobbies (Health Club, etc.) | | |
| | | |

Medical Data

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|------------------------------------|-------|-------------------------|
| Clinic or Emergency Room | | Date First Seen |
| Inpatient? • Yes • No | Dates | |
| Hospital | | |
| Address (Street, City, State, ZIP) | | |
| Attending Physician | | Telephone Number () |
| Family Doctor | | Telephone Number () |
| Address (Street, City, State, ZIP) | | |
| Parts of Body Injured | | |
| | | |
| | | |

NATURE OF INJURY

Abrasion _____ Fracture _____
 Aspiration _____ Laceration _____
 Bite _____ Poisoning _____
 Bruise _____ Puncture _____
 Burn _____ Scalds _____
 Concussion _____ Scratches _____
 Cut _____ Shock (el.) _____
 Dislocation _____ Sprain _____
 Other (specify) _____

PART OF BODY INJURED

Back _____ Arm (____R / ____L)
 Chest _____ Ear (____R / ____L)
 Face _____ Elbow (____R / ____L)
 Finger _____ Eye (____R / ____L)
 Head _____ Foot (____R / ____L)
 Mouth _____ Hand (____R / ____L)
 Nose _____ Knee (____R / ____L)
 Scalp _____ Leg (____R / ____L)
 Tooth _____ Wrist (____R / ____L)
 Other (specify) _____

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|---------------------|
| Prior Injuries |
| Prior W.C. Injuries |

A person who knowingly and with the intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

I hereby declare that the facts stated are true

Signed X _____ **Date** _____