



Every child is a work of art.
Create a masterpiece.

WORKERS' COMPENSATION FIRST REPORT OF INJURY AND ILLNESS

Answer ALL questions. Sign, and give to your supervisor immediately. Please make and retain a copy for your records.

Section I: EMPLOYEE INFORMATION

Last Name			First Name			Middle Initial		
Telephone Number	Date of Birth	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number		Average Weekly Salary		
Address				City		State	Zip Code	
Occupation/Title		Date of Hire	Work Status <input type="checkbox"/> full-time <input type="checkbox"/> part-time		Hours/day	Hours/week	Department	
School Building / Location Accident Occurred (Street, City, Zip Code)					Immediate Supervisor			

Section II: EMPLOYEE MEDICAL INFORMATION

Medical Treatment Received? Y N *(If no medical treatment, proceed to Section III)*

****Should the injured employee receive medical treatment after the initial incident report, the employee can contact UMR at 1-844-368-6663 or the RCSD Human Resources Director at 585-262-8562 to provide information.****

Any Lost Time <input type="checkbox"/> Y <input type="checkbox"/> N	If yes, date disability began	If out of work: will salary be continued
Name of Attending Physician		Inpatient Hospitalization
Address of Attending Physician		Name of Hospital
City	State	Zip Code
City	State	Zip Code

Section III: INCIDENT INFORMATION *(Please complete the entire section)*

Date of Injury or Illness: (Month/Day/Year)	Time of Injury/ Illness	<input type="checkbox"/> AM <input type="checkbox"/> PM
Is This a Recurrence of a Previous Injury or Illness <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "Yes" Please Give Details (i.e., date of previous Injury and provide details)		
Describe Part (s) of Body Injured/Nature of Occupational Illness (i.e., left arm, right foot, head, multiple, etc.)		
Nature of Injury / Illness (i.e., laceration, burns, fracture, strain, etc.)		
Cause of Injury / Illness (motor vehicle, machine, strain, or injury by lifting, etc.)		
Injury/Occupational Illness Description		
If Employee Unavailable for Signature, Explain Circumstances in this Space and Enter Incident		

OVER →



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Employee Signature

Date

SECTION IV: WITNESS(ES)

Yes No

Name (please print)

Phone #

Name (please print)

Phone #

SECTION V: SUPERVISOR INFORMATION

Date Supervisor Notified: (Month/Day/Year)

Time Supervisor Notified:
 AM PM

Principal/Supervisor Name (please print)

Principal/Supervisor Signature

Date

BY SIGNING THIS FORM, YOU ARE AFFIRMING THAT ALL INFORMATION PROVIDED BY YOU IS TRUE. PLEASE NOTE THAT KNOWINGLY MAKING A FALSE STATEMENT IN CONNECTION WITH AN APPLICATION FOR WORKERS' COMPENSATION OR DISABILITY BENEFITS IS A CRIME. ANY PERSON KNOWINGLY MAKING A FALSE STATEMENT IN CONNECTION WITH THIS APPLICATION MAY BE SUBJECT TO CRIMINAL PROSECUTION THAT COULD RESULT IN FINES AND/OR IMPRISONMENT.