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 ☐ M ☐ F	Social Security Number	Average Weekly Salary

Address	City	State	Zip Code

Occupation/Title	Date of Hire	Work Status ☐ full-time ☐ 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 POMCO at 1-877-236-7475 or the RCSD Risk Management Office at 262-8320 to provide information.*****

Any Lost Time ☐ Y ☐ 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	☐ AM ☐ PM

Is This a Recurrence of a Previous Injury or Illness

☐ Yes ☐ 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 →

WORKERS' COMPENSATION
FIRST REPORT OF INJURY AND ILLNESS

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.