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 UMR at 1-844-368-6663 or the RCSD Human Resources Director at 585-262-8562 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 →

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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.