GREAT FALLS PUBLIC SCHOOLS EMPLOYEES
ACCIDENT/ INJURY REPORT

NOTE: All blanks must be completed.

Last First M. I. Full name of INJURED EMPLOYEE	Date of Birth (mo/day/yr)	Social Security Number
Employee's Home Address (Street or Box No)	City	State / Zip Code
Phone Number	Gender	Marital Status: ◯ Married ◯ Single

Did employee return to work during next scheduled shift? ◯ yes ◯ no	If no, will wage loss exceed six work days ◯ yes ◯ no ◯ not sure	Last day worked date	Date of return, if returned to work

Describe how the accident happened, and give cause. Explain what employee was doing when injured. Be specific. Give full details on all factors which led or contributed to the accident. Use a separate sheet of paper if you need additional space.

What specific object or substance caused the injury?	Part of body affected (leg, arm, back, head, etc.)
Nature of the injury (cut, fracture, etc.) Date	and Time of Injury a.m. or p.m.
Job/position of Employee	
Names of witnesses to accident	Has Employee Notified Department Supervisor ◯ yes ◯ no
Did the accident occur on the District's premises? yes ◯ no ◯	Address or location where accident occurred:

Was worker injured while in your employ? ◯ yes ◯ no	Date Employer notified	Accident reported to:	Was safety equipment provided? ◯ yes ◯ no Was safety equipment used? ◯ yes ◯ no

Attending Physician's Name	Address (street or box)	City	State	Zip Code	Phone No
If Hospitalized, Hospital's Name	Address (street or box)	City	State	Zip Code	Phone No

Type of initial medical treatment received (please check ☐ No Treatment ☐ Emergency Room ☐ Treatment on-site ☐ Clinic/Dr. Office ☐ Hospitalization

Do you have any reason to question this accident? ◯ yes ◯ no	If Yes, please explain fully. Use separate sheet if you need additional space.

Report Filled Out By: _____ Date: _____

"This is my claim for workers' compensation benefits due to the on-the-job injury , occupational disease or death of the above named worker. I understand that signing this claim for compensation authorizes the release to the workers' compensation insurer or its agent, rehabilitation records, Social Security records and health care information (medical records, pursuant to HIPAA, Public Law 104-191, 42 USC section 130 1, et. seq., and section 39-71-604, MCA) that are directly relevant to the claimed injury, disease or death. I also understand that if I obtain or exert unauthorized control over workers' compensation benefits to which I am not entitled, I may be prosecuted for theft."

Signed _____ Date: _____
(Employee) I certify the above statement to be true and correct.

Signed: _____ Date: _____ Print Name: _____
(Supervisor or Principal)

Please send completed form to: Julie Shotnokoff, Lead Transportation/Safety Technician at the DOB SS _____
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