

## GREAT FALLS PUBLIC SCHOOLS EMPLOYEES ACCIDENT/ INJURY REPORT

**NOTE:** All blanks must be completed.

|  |  |    |                      |  |                                     |          |
|--|--|----|----------------------|--|-------------------------------------|----------|
| Last   | First  | M. | I.                   | Date of Birth (mo/day/yr)  | Social Security Number              |          |
| Full name of INJURED EMPLOYEE  |  |    |                      |  |                                     |          |
| Employee's Home Address (Street or Box No)   |  |    |                      | City   | State                               | Zip Code |
| Phone Number   |  |    | Gender               | Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single |                                     |          |
| Did employee return to work during next scheduled shift?<br><input type="checkbox"/> yes <input type="checkbox"/> no | If no, will wage loss exceed six work days<br><input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> 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                            |
| Job/position of Employee                             | a.m. or p.m.                                       |

|                                |  |
|--------------------------------|--|
| Names of witnesses to accident | Has Employee Notified Department Supervisor <input type="checkbox"/> yes <input type="checkbox"/> no |
|--------------------------------|--|

|   |  |   |   |          |          |
|---|--|---|---|----------|----------|
| Did the accident occur on the District's premises? <input type="checkbox"/> yes <input type="checkbox"/> no | Address or location where accident occurred: |   |   |          |          |
| Was worker injured while in your employ? <input type="checkbox"/> yes <input type="checkbox"/> no           | Date Employer notified                       | Accident reported to:   | Was safety equipment provided? <input type="checkbox"/> yes <input type="checkbox"/> no |          |          |
|   |  | Was safety equipment used? <input type="checkbox"/> yes <input type="checkbox"/> 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 <input type="checkbox"/> No Treatment <input type="checkbox"/> Emergency Room <input type="checkbox"/> Treatment on-site <input type="checkbox"/> Clinic/Dr. Office <input type="checkbox"/> Hospitalization | If Yes, please explain fully. Use separate sheet if you need additional space. |
| Do you have any reason to question this accident? <input type="checkbox"/> yes <input type="checkbox"/> no  |  |

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 1301, 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)