SPRINGFIELD CITY SCHOOL DISTRICT
WORKPLACE ACCIDENT REPORT

Name_____ Social Sec. No._____

Home Address_____ Birth Date_____ Sex: ☐ Male ☐ Female

City/State/Zip_____ Contact Telephone #: ( )_____

Job Title_____ Date of Hire_____

Location of Accident_____

Date of injury **or** onset of symptoms_____ Time_____ ☐ am ☐ pm

Described what caused the injury/symptoms, what you were doing **just before** the incident, and what you did **after** the incident (if you need more space, write on the back of this form). **Be specific - name any objects or substances involved:**_____

_____

_____

_____

_____

_____

Type of Injury. This section to be completed for all accidents.

☐ Abrasion	☐ Concussion	☐ Strain/Sprain	☐ Fracture
☐ Bruise	☐ Cut	☐ Laceration	☐ Puncture
☐ Burn	☐ Dislocation	☐ Other, specify: _____	

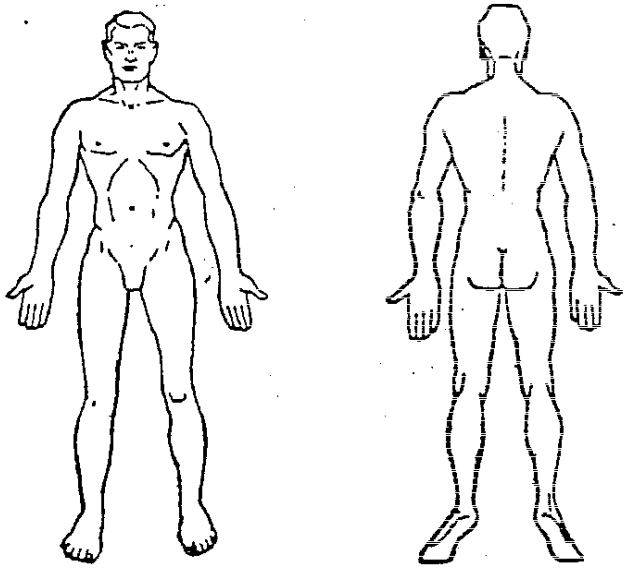
Part of body involved. This section to be completed for all accidents. If Back Injury, also complete Back injury form

left	right	left	right	left	right	left	right
☐ Chest	☐	☐ Neck	☐	☐ Shoulder	☐	☐ Hip	☐
☐ Back	☐	☐ Teeth	☐	☐ Upper arm	☐	☐ Upper leg	☐
☐ Abdomen	☐	☐ Face	☐	☐ Lower arm	☐	☐ Lower leg	☐
☐ Groin	☐	☐ Eye	☐	☐ Elbow	☐	☐ Knee	☐
☐ Ear	☐	☐ Nose	☐	☐ Scalp	☐	☐ Toes	☐
☐ Fingers	☐	☐ Ankle	☐	☐ Mouth	☐	☐ Hand	☐

☐ Additional Part of Body Description: _____

Cause of Incident. This section to be completed for all accidents.

☐ Animal/Insect bite	☐ Collision with person	☐ Toxic substance	☐ Fighting
☐ Struck by vehicle	☐ Struck by object	☐ Collision with object	☐ Lifting
☐ Exposure to weather	☐ Exposure to blood	☐ Hot surface/substance	☐ Slip/trip/fall
☐ Other, specify: _____			



Please color any injured body parts on these images

Did anyone see you get hurt? ☐ Yes ☐ No If yes, who?_____

Did you report this incident to anyone? ☐ Yes ☐ No If not, why not?_____

If yes, to whom did you report it?_____ Title/Position_____ When?_____

Was any first aid provided at the scene? ☐ Yes ☐ No If yes, describe:_____

_____

Will you seek medical treatment from a licensed medical professional? ☐ Yes ☐ No If yes, when?_____

I have been provided a copy of SCSD workplace injury procedures and our Managed Care System (MCO) is CompManagement Health System and the BWC medical provider will submit all medical bills related to this workplace injury to CompManagement Health Systems, Inc. 1-888-247-7799 ☐ Yes ☐ No

I certify that my statements are true and to the best of my knowledge.

Employee Name (print) _____

Employee Signature _____ Date (required) _____

Medical Release

Under current workers' compensation provisions, the employer is entitled to a signed medical release

I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to **disclose such information** to my employer, my employer's managed care organization, or to my employer's designated representative, **CompManagement, Inc.** A copy of this form will serve as the original.

Employee Name (print)_____

Employee Signature_____ Date (required)_____