LABBB
Collaborative Programs

Workers Compensation Report Form

Employee Information

Name: _____ **Social Security Number:** _____

Address: _____ **Date of Birth:** _____

Cell Number: _____ **Home Number:** _____ **Work Number:** _____

Marital State: (Single) / (Married) **Gender:** (Male) / (Female)

School/Program: _____ **Position:** _____

Salary: _____ **Weekly Wage (Salary/52):** _____ **Date of Hire:** _____

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Details of Incident

Date of Incident: _____ **Time of Incident:** _____

Location of Incident (BE SPECIFIC - e.g. inside classroom 105, parking lot of Burlington High School, etc.):

_____.

Description of Incident (including any injuries): _____

_____

_____.

Were there any witnesses? (Yes) / (No) If yes, please provide their name and number.

Witness #1: _____

Witness #2: _____

To whom was the incident reported (Name & Position)? _____

Have you or do you plan on seeking medical treatment? (Yes) / (No) If yes, provide the facility's name & phone number.

Medical Facility (including address): _____

Phone #: _____ **Date & Time of Treatment:** _____

Employee Signature: _____ **Date:** _____

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All forms MUST be sent to Human Resources the same day an incident occurs.

Supervisor Information

Name: _____ **Position:** _____ **Phone #:** _____

Has the employee missed work due to incident? (Yes) / (No)

If yes, provide length of time already missed as of the submission of this form**:** _____

Has the employee returned to work? (Yes) / (No)

If no, provide length of time employee has communicated they will be out of work**:** _____

Description of Incident (include whether you saw the incident occur): _____

_____

_____

_____.

Cause of Incident (BE SPECIFIC – e.g. did he/she fall while standing on a chair, was their snow/ice on the ground, was the floor wet when they slipped, restraining a student, etc.): _____

_____

_____

_____.

Misc. Supervisor Notes: _____

_____.

Supervisor Signature: _____ **Date:** _____

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HR Information

Date/Time report received: _____

Date/Time reported to MEGA's Insurance: _____

Claim #: _____

Date/Time claim # sent to employee: _____

Date/Time claim was closed: _____

Misc. HR Notes: _____

_____

_____

All forms MUST be sent to Human Resources the same day an incident occurs.