EMPLOYEE'S REPORT OF INCIDENT AND INJURY
PLEASE PRINT IN INK To be completed by Employee

Employer: North Central State College **Policy No: 30006721**

Location of Injury/Incident: _____

Name_____ Social Sec. No._____

Home Address_____ Birth Date_____ Sex: ☐ Male ☐ Female

City/State/Zip_____ Telephone: ( )_____

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:**_____
_____
_____
_____

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?_____

What part(s) of your body was/were affected? (BE SPECIFIC: for example, right elbow, left knee, right index finger):
_____
_____

What type of injury did you experience? (BE SPECIFIC: for example, bruise, scrape, laceration, pull)_____
_____

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

Did you seek other medical treatment? ☐ Yes ☐ No If yes, when?_____
Where?_____ If treatment was not sought immediately, explain why: _____
_____

Is this an aggravation of a previous injury/symptom? ☐ Yes ☐ No If yes, when were you last treated for the previous injury? _____ By whom or where?_____

Have you ever had a similar injury? ☐ Yes ☐ No If yes, describe other injury:_____
_____

Medical Release

Under current workers' compensation law, 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)_____