USD 447 – Cherryvale-Thayer Schools

WORKERS' COMPENSATION ACCIDENT/ILLNESS REPORT FORM

(For reporting work-related injuries/illnesses)

The injured worker and supervisor must complete and file this report with the Central Office, 618 East 4th Street, Cherryvale, Kansas 67335 WITHIN 24 HOURS of any on-the-job injury.

PART A: INJURED WORKER'S STATEMENT OF ACCIDENT/ILLNESS			
Employee Name (Last Name, First Name):			Job Assignment/title:
Home address:			SSN:
Home phone:	Date of Birth:		Work phone:
Date of occurrence:	Time of accident:	Location of injury occurrence:	
How was injury incurred:		Time employee began work:	
Were you ever treated for a similar condition before:		Body part(s) injured:	
If yes, give details:			

Employee's Signature:_____ **Date:**_____

Part B: SUPERVISOR'S STATEMENT		
Injury:		Payroll Location:
Name and address of hospital or physician:	Did injured worker receive medical treatment:	Date:
Object or machinery causing injury:		
Was there contact with any other person's blood or body fluid:		
If yes, name and address of source person:	Did weather conditions contribute to occurrence:	
How could a similar occurrence be avoided:	If yes, what were the weather conditions:	
Name and phone number of witnesses (if any):		
Did injured worker lose time from work:	If yes, first full day of disability:	
Has the injured worker returned to work:	If yes, date returned:	
Supervisor's Name:	Signature:	
Phone ext:	Date Completed:	