

# 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 4<sup>th</sup> 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:	