SCHOOL EMPLOYEES LOSS FUND (SELF)

Employee's Report of Injury

Information About You

District Name & # ______________________________

Employee Name: ______________________________

Address: ______________________________

Phone #: ______________________________

Marital Status: S ☐ M ☐ D ☐ W ☐ Sex: M ☐ F ☐

Children under 18 (sex and age): ______________________________

Height: ______________ Weight: ______________ Average Weekly Wage: ______________

Length of Employment: ______________ Days & Hours Worked: ______________

Other Employment: ______________________________

Information About the Accident

Date of Accident: ______________ Time: ______________

Place of Accident: ______________________________

____

What were you doing before the accident? ______________________________

____

What happened? ______________________________

____

____

Witnesses Name , if any: ______________________________

____

Who did you report the injury to? ______________________________

____

What date did you report it? ______________________________

____

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Information About the Injury

What part of your body was injured? ____________________

Any other part or parts injured? ____________________

What kind of injury (strain, cut, broken bone)? ____________________

____

Exact location of pain(s): ____________________

____

Information About the Treatment

What doctor is treating you (name, address, phone #)? ____________________

____

Who is your family doctor? ____________________

What clinic is treating you? ____________________

What hospital is treating you? ____________________

What treatment are you getting (medication, physical therapy, rest, etc.)? ____________________

____

Has the doctor told you to be off work? ____________________

____

General Information

Have you ever injured the same part of your body before? ____________________

Explain: ____________________

Have you ever injured any other part of your body before? ____________________

Explain: ____________________

Do you have any serious illness (Diabetes, High Blood Pressure, etc.)? ____________________

Explain: ____________________

Have you understood the questions you have answered? ____________________

Signed: ____________________

Date:

Return this form to your Supervisor