VERNON PUBLIC SCHOOLS

EMPLOYEE INJURY REPORTING FORM

Today's Date: _____

Date of Incident:	**Time of Incident:**	**Time Workday Began:**
Incident Address:		
Incident Reporter Name:		**Phone:**

Claimant Name:		**DOB:**
Home Address:		**Marital status**: □ **S** □ **M** □ **D** □ **W**
City:	**State:**	**ZIP:**
Home Phone:	**Work Phone:**	
Job Title:	**Work Status:** □ **FULL TIME** □ **PART TIME** □ **TEMP**	
Supervisor Name:		**Phone:**
To whom did you report the incident?		
Specific location at address where incident took place:		
Treated by Nurse/Employer: □ **YES** □ **NO**	**Went to CorpCare:** □ **YES** □ **NO**	**Refused Medical Attention:** □ **YES** □ **NO**
Other Medical Provider: □ **YES** □ **NO**	**Name/Address:**	

Describe bodily injury sustained including specific affected body parts (i.e. left/right, inner/outer, etc.):

Describe how the incident occurred including events leading up to the incident (i.e. what you saw or heard):

On-site treatment received:
List all equipment, materials, and/or chemicals you were using when incident or exposure occurred:
Were safeguards or safety equipment provided □ YES □ NO □ N/A **If provided, were they used? □ YES □ NO**
Witness to the incident? □ YES □ NO If yes, please list name(s): **(Witness should complete an Accident Statement form.)**
Do you have a pre-existing injury to the affected area(s)? □ YES □ NO **If yes, describe previous injury including date:**

Claimant Signature:	**Date:**

ALL INJURIES SHOULD BE REPORTED WITHIN 24 HOURS OF ACCIDENT/INCIDENT.
Please fax to Central Office at 860-870-3765 or email to: safety@vernon-ct.gov.

OFFICE USE ONLY:

CIRMA Ref. #		Work Restrictions?	□ Yes □ No
Date Entered:		Restrictions Accommodated?	□ Yes □ No
Social Security #		Date of Hire:	
Lost time from work: □ YES □ NO		Return to Work Date (if known):	