

FIRST REPORT OF INJURY

Date of Report: ____/____/____

Date Notified Employer: ____/____/____

Date of Injury: ____/____/____ Time of Injury: ____:____ AM/PM (circle one)

Edustaff Employee Information:

Employee Name (Last, First, Middle): _____

SSN: _____ - _____ - _____ DOB: ____/____/____ Sex: M/F (circle one)

Address (Number & Street): _____

City: _____ State: _____ Zip: _____

Phone Number: _____ - _____ - _____ Hire Date: ____/____/____

Job Title: _____

Injury Report Information:

Job Location: _____

DISTRICT: _____

Start Time: ____:____ AM/PM (circle one) End Time: ____:____ AM/PM (circle one)

Address (Number & Street): _____

City: _____ State: _____ Zip: _____

Witness to Injury: _____ Witness Phone Number(s): _____ - _____ - _____

Explain How Injury Occurred: _____

Nature of Injury: _____



Part of the body directly affected by the injury: _____

Last Day Worked: ____/____/____ Date Employee Returned: ____/____/____

Was the injury fatal? Yes/No (circle one) If yes, date of fatality: ____/____/____

Did employee seek medical treatment? Yes/No (circle one)

If yes, date of treatment: ____/____/____

Name of treatment facility: _____

Address (Number & Street): _____

City: _____ State: _____ Zip: _____

Restrictions: _____

Expected return to work date: ____/____/____

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District Information:

Building Supervisor: _____
(printed name and signature)

Phone Number: ____-____-____

Date: _____

Feedback: _____

Please return via email to the Human Resources Office at humanresources@monroe.k12.mi.us or via fax to 734-265-3021.

AUTHORIZATION FOR TREATMENT Workers Compensation

This form authorizes a health care provider to treat the following EDUStaff Employee:

for a work related injury that occurred on _____

at _____.

Send all billing information to:

Accident Fund
PO Box 40790
Lansing, MI 48901
Policy #100100699