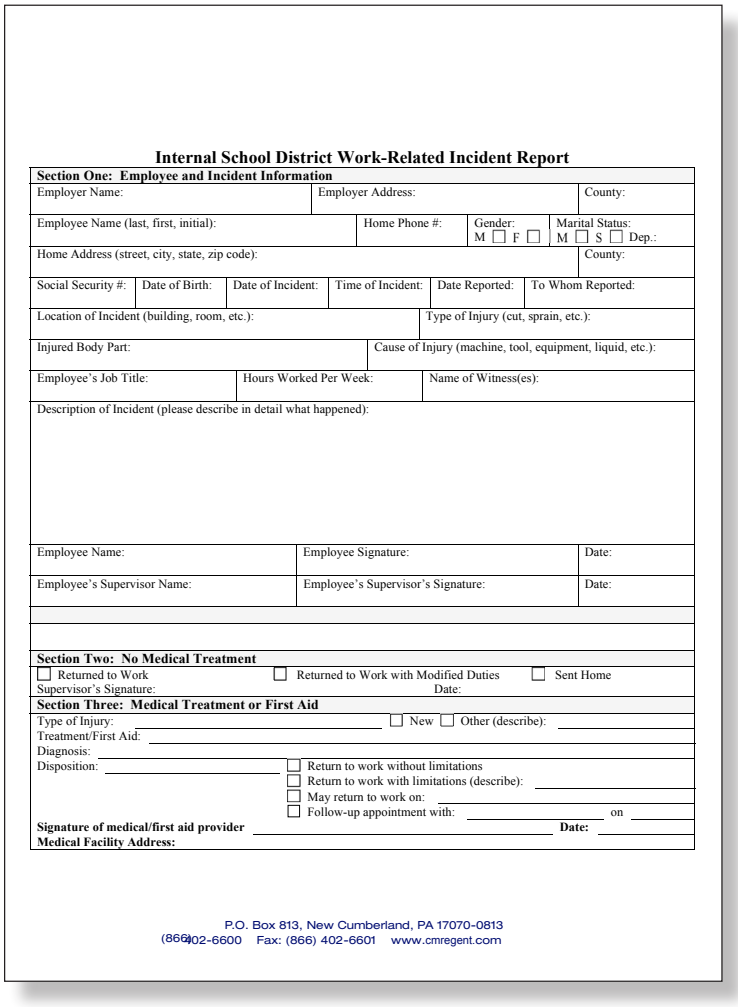
Internal Work-Related Incident Form

WHAT IS IT: Internal form for school districts to use to gather information at the time an injury takes place. This form will be used to complete the CM Regent online injury report.

IMPORTANCE: Provides an immediate resource to memorialize facts and document information.

HOW FORM IS USED: This document can be used by any school for internal tracking of information and is especially useful for those districts with more than one location. The completed form can be shared with the person responsible for online reporting of injury claims.



Internal School District Work-Related Incident Report

Section One: Employee and Incident Information

Employer Name:		Employer Address:			County:
Employee Name (last, first, initial):		Home Phone #:	Gender: M ☐ F ☐	Marital Status: M ☐ S ☐ Dep.:	
Home Address (street, city, state, zip code):					County:
Social Security #:	Date of Birth:	Date of Incident:	Time of Incident:	Date Reported:	To Whom Reported:
Location of Incident (building, room, etc.):			Type of Injury (cut, sprain, etc.):		
Injured Body Part:			Cause of Injury (machine, tool, equipment, liquid, etc.):		
Employee's Job Title:	Hours Worked Per Week:		Name of Witness(es):		
Description of Incident (please describe in detail what happened):					
Employee Name:		Employee Signature:			Date:
Employee's Supervisor Name:		Employee's Supervisor's Signature:			Date:

Section Two: No Medical Treatment

☐ Returned to Work ☐ Returned to Work with Modified Duties ☐ Sent Home

Supervisor's Signature: Date:

Section Three: Medical Treatment or First Aid

Type of Injury: ☐ New ☐ Other (describe):

Treatment/First Aid:

Diagnosis:

Disposition: ☐ Return to work without limitations

☐ Return to work with limitations (describe):

☐ May return to work on:

☐ Follow-up appointment with: on

Signature of medical/first aid provider **Date:**

Medical Facility Address:

P.O. Box 813, New Cumberland, PA 17070-0813
(866) 402-6600 Fax: (866) 402-6601 www.cmregent.com

CM REGENT INSURANCE COMPANY

Internal School District Work-Related Incident Report

Section One: Employee and Incident Information

Employer Name:		Employer Address:			County:
Employee Name (last, first, initial):		Home Phone #:	Gender: M ☐ F ☐		Marital Status: M ☐ S ☐ Dep.:
Home Address (street, city, state, zip code):					County:
Social Security #:	Date of Birth:	Date of Incident:	Time of Incident:	Date Reported:	To Whom Reported:
Location of Incident (building, room, etc.):			Type of Injury (cut, sprain, etc.):		
Injured Body Part:			Cause of Injury (machine, tool, equipment, liquid, etc.):		
Employee's Job Title:		Hours Worked Per Week:	Name of Witness(es):		
Description of Incident (please describe in detail what happened):					
Employee Name:		Employee Signature:			Date:
Employee's Supervisor Name:		Employee's Supervisor's Signature:			Date:

Section Two: No Medical Treatment

☐ Returned to Work ☐ Returned to Work with Modified Duties ☐ Sent Home

Supervisor's Signature: Date:

Section Three: Medical Treatment or First Aid

Type of Injury: _____ ☐ New ☐ Other (describe): _____

Treatment/First Aid: _____

Diagnosis: _____

Disposition: _____

☐ Return to work without limitations

☐ Return to work with limitations (describe): _____

☐ May return to work on: _____

☐ Follow-up appointment with: _____ on _____

Signature of medical/first aid provider _____ **Date:** _____

Medical Facility Address: