


▶ 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 Insurance Company 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.

 Workers' Compensation Division 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 <input type="checkbox"/> F <input type="checkbox"/>	Marital Status: M <input type="checkbox"/> F <input type="checkbox"/> Dep.: <input type="checkbox"/>	
Home Address (street, city, state, zip code):					County:	
Social Security #:	DOB:	Date of Incident:	Time of Incident:	Date Reported:	To Whom Reported:	Start Time:
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						
<input type="checkbox"/> Returned to Work <input type="checkbox"/> Returned to Work with Modified Duties <input type="checkbox"/> Sent Home Supervisor's Signature: _____ Date: _____						
Section Three: Medical Treatment or First Aid						
Type of Injury: _____ <input type="checkbox"/> New <input type="checkbox"/> Other (describe): _____						
Treatment/First Aid: _____						
Diagnosis: _____						
Disposition: _____						
<input type="checkbox"/> Return to work without limitations <input type="checkbox"/> Return to work with limitations (describe): _____ <input type="checkbox"/> May return to work on: _____ <input type="checkbox"/> Follow-up appointment with: _____ on _____						
Signature of medical/first aid provider _____					Date: _____	
Medical Facility Address: _____						
300 Sterling Parkway, Suite 100, Mechanicsburg, PA 17050 (866) 402-6600 Fax: (866) 402-6601 www.CMRegent.com						



Workers' Compensation Division

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Employer Name:			Employer Address:			County:
Employee Name (last, first, initial):			Home Phone #:	Gender: M <input type="checkbox"/> F <input type="checkbox"/>	Marital Status: M <input type="checkbox"/> F <input type="checkbox"/> Dep.: <input type="checkbox"/>	
Home Address (street, city, state, zip code):					County:	
Social Security #:	DOB:	Date of Incident:	Time of Incident:	Date Reported:	To Whom Reported:	Start Time:
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						
<input type="checkbox"/> Returned to Work	<input type="checkbox"/> Returned to Work with Modified Duties		<input type="checkbox"/> Sent Home			
Supervisor's Signature:			Date:			
Section Three: Medical Treatment or First Aid						
Type of Injury: _____ <input type="checkbox"/> New <input type="checkbox"/> Other (describe): _____						
Treatment/First Aid: _____						
Diagnosis: _____						
Disposition: _____			<input type="checkbox"/> Return to work without limitations <input type="checkbox"/> Return to work with limitations (describe): _____ <input type="checkbox"/> May return to work on: _____ <input type="checkbox"/> Follow-up appointment with: _____ on _____			
Signature of medical/first aid provider _____					Date: _____	
Medical Facility Address: _____						