DEARBORN PUBLIC SCHOOLS
18700 Audette
Dearborn, MI 48124
EMPLOYEE REPORT OF INJURY

PLEASE WRITE LEGIBLY AND ANSWER ALL QUESTIONS. DO NOT USE PENCIL. COMPLETE BOTH SIDES OF FORM.

Date of Report _____

Employee Name _____ Social Security No. _____

Address _____
Street Address City State Zip

Phone Number _____ Date of Hire _____ Birthdate _____

Marital Status _____ Male _____ Female _____ Time employee reported to work _____ am pm

No. Hours Worked per day _____ Date of Injury _____ Time of Injury _____ am pm

School/Department _____ Occupation _____

Location of Accident _____ Specific Location _____

Describe Incident, please be specific _____

_____

Describe Injuries _____

_____

Employee's Signature _____ Supervisor's Signature _____

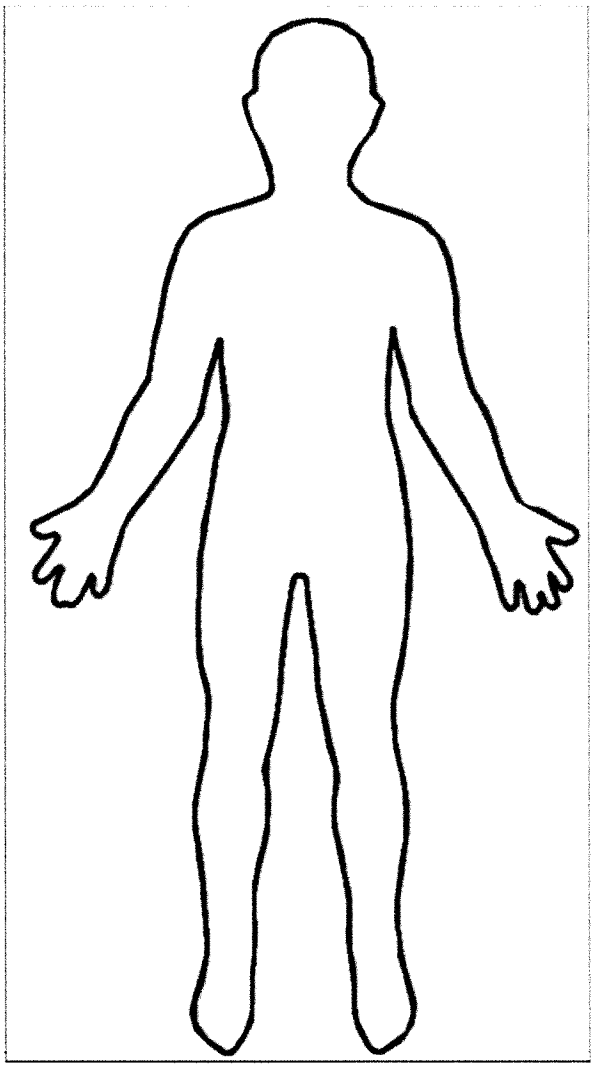
Witness _____ Supervisor's Phone No. _____

If no time was lost, please check here _____ **If you're declining treatment, please check here _____**

PLEASE READ THE FOLLOWING CAREFULLY: This injury report must be received in the Business Services Office within 24 hours of injury. If form is emailed or faxed, original must be sent to Business Services as well. It is the responsibility of the injured employee to report any accident/injury to his/her supervisor and fully complete this form. Employees are REQUIRED to treat at one of the approved medical facilities within 24 hours of the injury. Treatment must continue at the approved medical facility for the first 28 days after injury. Any employee who chooses to treat with his/her personal physician for the first 28 days will not be reimbursed for medical expenses. If employee chooses to change physicians after 28 days, the Business Services Office must be notified at 313-827-3018.

Rev. 10/2016

Right Side Left Side



Please indicate the body part(s) injured.

PLEASE PROVIDE ADDITIONAL INFORMATION IF NECESSARY:

_____

_____

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