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.

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		Worke	ers' Comp	pensatio	n Division								
1	nternal	School Dist	rict W	ork-R	elated	Inc	ider	t R	epoi	rt			
	ployee and l	Incident Informa											
Employer Name:		Employ	Employer Address:						County:				
Employee Name (1	ast, first, initial		Home Phone #: Gender:						l Status:] F Dep.:				
Home Address (stree	et, city, state, zi	ip code):				1				County:			
Social Security #:	DOB:	Time of I	Time of Incident: D			To W	eportec	1: Start Time:					
Location of Incident	(building, roor		Type of Injury (cut, spra					, etc.):	1				
Injured Body Part:			Cause of Injury (machine, tool, equipm						iquid, etc.):				
			Week: Name of Witness(es):										
Employee's Job Titl	e:	Hours Work	ed Per Wee	k:	Name o	of Wit	ness(e	i):					
		Hours Work		·k:	Name (of Wit	ness(e	s):					
Description of Incident		cribe in detail what h	appened):			of Wit	ness(e	s):		Date:			
Description of Incident of Inc	ent (please desc	scribe in detail what h	Employee	Signature:			ness(e	s):					
Description of Incident	ent (please desc	scribe in detail what h	appened):	Signature:			ness(e	s):		Date:			
Employee Name: Employee's Supervi	ent (please desc	cribe in detail what h	Employee	Signature:			ness(e	s):					
Employee Name: Employee's Supervi	sor Name:	cribe in detail what h	Employee	Signature: s Supervis	or's Signatu	re:				Date:			
Employee Name: Employee's Supervi Section Two: No Returned to Wor	ent (please desc sor Name:	cribe in detail what h	Employee:	Signature: s Supervis	or's Signatu	re:				Date:			
Employee Name: Employee's Supervi Section Two: No Returned to Wor Supervisor's Signatures Section Three: N	ent (please desc sor Name:	cribe in detail what h	Employee Employee	Signature: s Supervis	or's Signatu Modified Du Date:	re:			Sent Ho	Date:			
Employee Name: Employee's Supervi Section Two: No Supervisor's Signatu Section Three: N Type of Injury.	sor Name: Medical Tra k ure:	cribe in detail what h	Employee' Employee'	Signature: s Supervis	or's Signatu	re:			Sent Ho	Date:			
Employee Name: Employee Name: Employee's Supervi Section Two: No Returned to Wor Supervisor's Signant Section Three: Type of Injury: Treatment/First Aid: Diagnosis:	sor Name: Medical Tre k ure: Jedical Trea	eatment Reatment or First Al	Employee Employee Employee	Signature: s Supervis	or's Signatu Modified Du Date:	re:			Sent Ho	Date:			
Employee Name: Employee Name: Employee's Supervi Section Two: No Returned to Wor Supervisor's Signant Section Three: Type of Injury: Treatment/First Aid: Diagnosis:	sor Name: Medical Tre k ure: Jedical Trea	reatment Reatment or First Al	Employee: Employee' Eturned to Wid	Signature: s Supervise Vork with !	or's Signatu Modified Di Date: New	re:	descri		Sent Ho	Date:			
Employee Name: Employee's Supervi Section Two: No Supervisor's Signatu Section Three: N Type of Injury.	sor Name: Medical Tre k ure: Jedical Trea	eatment Ree	Employee Employee Employee Employee Employee Employee	Signature: s Supervis Vork with !	or's Signatu Modified Duate: New ut limitations (imitations (i	re:	descri		Sent Ho	Date:			
Employee Name: Employee's Supervi Section Two: No Returned to Wor Supervisor's Signant Section Three: N Type of Injury: Treatment/First Aid: Diagnosis:	sor Name: Medical Tre k ure: Jedical Trea	reatment Reatment or First Ai	Employee : Employee : Eturned to W Return to v Return to v May return	Signature: s Supervis Vork with P	or's Signatu Modified Du Date: New	re:	descri		Sent Ho	Date:			
Employee Name: Employee's Supervi Section Two: No Returned to Wor Supervisor's Signant Section Three: N Type of Injury: Treatment/First Aid: Diagnosis:	sor Name: Medical Trek k ure: 1edical Trea	reatment Rea	Employee Employee Employee Employee Employee Employee	Signature: s Supervis Vork with P	or's Signatu Modified Du Date: New	re:	descri		Sent Ho	Date:			



Workers' Compensation Division

Internal School District Work-Related Incident Report

Section One: Em	ployee and I	ncide	nt Informati	ion											
Employer Name:				Employer Address:						County:					
Employee Name (last, first, initial):					Home Phone #:			Gei M	nder:	Marital Status: M F Dep.:					
Home Address (street, city, state, zip code):												County:			
Social Security #:	ocial Security #: DOB: Date of Incident:					Date	Date Reported: To Whom				Repor	ted:	Start Time:		
Location of Incident		Type of Injury (cut, sprain							n, etc.):						
Injured Body Part:					Cause of Injury (machine, tool, equip							ment, liquid, etc.):			
Employee's Job Title: Hours Wor			Hours Worke	ed Per Week: Name				of Witness(es):							
Employee Name:				Employee Signature:								Date:			
Employee's Supervisor Name:			Employee's Supervisor's Signature:								Date:				
Section Two: No	Medical Tre	atme	nt												
Returned to Work				urned to W	ork with	Modi	ified Dut	ies			Sent l	Home	;		
Supervisor's Signatu							Date:								
Section Three: M	ledical Treat	ment	or First Aid	l											
Type of Injury:						New	v 🗌 O	ther	(desc	ribe): ₋					
Treatment/First Aid:															
Diagnosis:															
· ·				Return to work without limitations											
				Return to work with limitations (describe):											
				May return	ay return to work on:										
					y-up appointment with:										
					Date: _						e:				
Medical Facility Ad	ldress:														