EMPLOYEES REPORT OF INCIDENT AND INJURY

PLEASE PRINT IN INK — To be completed by employee — CLINTON COUNTY

Last Name, First Name, Middle Initial			Telephone Number	Social Security Number	Date of Birth
Home Address			Sex: ☐ Male ☐ Female	Occupation:	
City	State	9-digit Zip Code	County	Department Name:	

1. Date of injury or onset of symptoms _____ Time _____ ☐ a.m. ☐ p.m.

Describe what caused the injury/symptoms, what you were doing just **before** the incident, and what you did after the incident (if you need more space, write on the back of this form). **Be specific - name any object(s) or substance(s) involved:**

_____

_____

_____

_____

2. Did you report this incident to anyone? ☐ Yes ☐ No If No, why not? _____

If Yes, to whom did you report it? _____ Title/Position _____ When? _____

Did anyone else see what happened? ☐ Yes ☐ No If Yes, who? _____

_____

(If there are any additional names, please list them on the back of this form)

3. **What part(s) of your body was/were affected? (BE SPECIFIC:** for example, right elbow, left knee, right index finger, etc.)

_____

_____

_____

What type of injury did you experience? (BE SPECIFIC: for example, bruise, scrape, laceration, pull, etc.)

_____

_____

4. Was any first aid provided at the scene? ☐ Yes ☐ No If Yes, please describe: _____

_____

Did you seek other medical treatment? ☐ Yes ☐ No If Yes, when? _____

Where: _____ If treatment was not sought immediately, explain why not:

_____ _____

_____ _____

Last day worked: _____ Returned to work: _____ If not returned, estimated date of return: _____

5. Is this an aggravation of a previous injury/symptom? ☐ Yes ☐ No If Yes, when were you last treated for the previous injury? _____ By whom? _____

Have you ever had a similar injury? ☐ Yes ☐ No If Yes, please describe the other injury: _____

_____

MEDICAL RELEASE

Under current workers' compensation law, the employer is entitled to a signed medical release

I hereby authorize any person or persons who have in the past or will in the future medically attend, treat, or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to disclose such information to my employer and/or to CompManagement, Inc. (representative of employer). A copy of this form will serve as the original.

Employee Name (Print) _____

Employee Signature _____ Date (Required) _____

EMPLOYEES REPORT OF INCIDENT AND BACK INJURY

PLEASE PRINT IN INK — To be completed by employee when back injury is reported — CLINTON COUNTY

Last Name, First Name, Middle Initial			Telephone Number	Social Security Number	Date of Birth
Home Address			Sex: ☐ Male ☐ Female	Occupation:	
City	State	9-digit Zip Code	County	Department Name:	

1. What part of your back hurts now? _____

When did you first notice this back pain? Date: _____ Time: _____ a.m. _____ p.m.

What were you doing at that time? (Explain in detail) _____

_____

_____

If you were lifting an object, what was it, and how heavy was it? _____

_____

What was your exact position when pain was first noticed? _____

What did you feel? _____

What was the length of time between the injury and your disability? _____

2. Did anyone see you get hurt? ☐ Yes ☐ No If Yes, who? _____

Did you report or mention this injury to anyone? ☐ Yes ☐ No If Yes, who and when? _____

_____

3. Did you ever have a back injury before? ☐ Yes ☐ No If so, when? _____

What part of your back? _____

Were you treated by a doctor? ☐ Yes ☐ No If so, when? _____

Has it given you further trouble since then? _____

4. Have you ever received or filed for compensation because of a back injury? ☐ Yes ☐ No; Other injury? ☐ Yes ☐ No

If so, list Bureau of Workers' Compensation claim number(s): _____

MEDICAL RELEASE

Under current workers' compensation law, the employer is entitled to a signed medical release

I hereby authorize any person or persons who have in the past or will in the future medically attend, treat, or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to disclose such information to my employer and/or to CompManagement, Inc. (representative of employer). A copy of this form will serve as the original.

Employee Name (Print) _____

Employee Signature _____ Date (Required) _____