WORKERS' COMPENSATION OCCUPATIONAL INJURY REPORT

Workers Having Accident/Injury Complete This Form
(Must be in Finance Workers' Compensation Division within 48 hrs)

Injury No. _____
(Do Not Fill in – Office Use Only)

INSTRUCTION
Please read all before filling out form.

1) Individual employee reporting an accident and/or injury to self must complete this side of form. Please answer all items.

2) Please complete this form even if you do not seek medical aid.

3) Any employee having an occupational illness, accident, injury – Please fill out this form.

4) Original signed (signature) report must be sent to the Finance Dept. Office of Workers' Compensation within 48 hrs of the occurrence of the accident, simultaneously a copy must be sent to the County Manager.

5) A copy of these reports must be sent to your Department Safety Person to be placed in Department Safety files.

_____

Note: PR-1200-5 – Injury Leave – was revised March 20, 1991. Injury Leave will be granted only in Catastrophic injuries, i.e., loss of limb, loss of eye sight, burn victims, ect.….

Employee Name: _____
(As Shown on Payroll)
Social Security No.: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Off Days: _____

Department: _____ Division: _____

Work Location: _____

Date of Injury: _____ Time of Injury: _____

Place of Accident

Street No. & Name: _____City: _____

Witness: _____ Witness: _____

Did injury occur on the job? ☐ describe your injury or injuries in detail and indicate the parts of the body affected. (For example: left arm, right arm ect.) _____

Explain the accident (what specifically was the employee doing at the time of the accident)

Do you work a second job? Yes ☐ No ☐ if yes, give the following information:

Name of Company: _____

Address: _____

Tele. No.: _____ Immediate Supervisor: _____

Name and Address of Physician Who Treated You: _____

Name and Address of Hospital Where You Were Treated: _____

Authorizing Treating Facility referring you to Hospital: _____

For the first seven days of loss time you must check one of the following. No Workers' Compensation is paid for first seven days unless you are absent over 21 days.

LWOP ☐ Vacation ☐ Sick ☐ Compensatory ☐

After Seven (7) days you must elect one of the following:

Workers Compensation ☐ (66 2/3 of average weekly wage NTE amount set by State Workers' Comp. Law)

Vacation ☐ Sick ☐ Compensatory ☐

I certify that all information given above is true and correct to the best of my knowledge and belief. I understand that my willful and intentional falsification of any information on this accident report will result in loss of benefits.

Signature of Employee _____ Home Telephone (Area Code) (_____) _____ - _____

Home Address _____
Street No. Street Name City (No P.O. Box Number Allowed Please)

(If employee is unable to sign, please submit supplemental report until signature can be obtained.)

(SUPERVISOR PLEASE COMPLETE REVERSE SIDE)

FULTON COUNTY SUPERVISOR'S REPORT OF INJURY/ACCIDENT

PURPOSE: **To make a written record of what happened, discover the causes, and correct them so the accident will not reoccur.**

It is the Supervisor's responsibility to insure the reverse side (WORKERS' COMPENSATION OCCUPATIONAL INJURY REPORT) is filled out completely by the employee and signed by the employee. IT IS YOUR RESPONSIBILITY AS THE SUPERVISOR TO REPORT AN INJURY IMMEDIATELY.

Department-Shift:	Job Title:	How long on this job?

Place of Accident: _____ **Date & Time of Accident:** _____

To Whom Reported: _____ **Date & Time Reported:** _____

HOW DID IT HAPPEN?

_____

_____

_____

Get all the facts by studying the job and situation involved.

Question by use of WHY – WHAT WHERE – WHEN – WHO – HOW

What job was the employee performing at the time he/she was injured? _____

Describe the accident (what happened, who was involved, what tools or equipment was involved, ect.)

_____

_____

Describe the injury (part of body, cuts bruises, ect.) _____

_____

Was Personal Protective Equipment required? Yes ☐ **No** ☐ **if YES, was Personal Protective Equipment properly utilized? Yes** ☐ **No** ☐

If NO, explain why not? _____

_____

WHAT SHOULD BE DONE?

_____

_____

_____

Determine which of the 12 items require additional attention.

Equipment:	Material:	People:
Select	Select	Select
Arrange	Place	Place
Use	Handle	Train
Maintain	Process	Lead

List preventative action taken: _____

_____

WHAT HAVE YOU DONE THUS FAR?

_____

OBJECTIVE
Eliminate Job Hindrances

List steps which need to be taken: _____

HOW WILL THIS IMPROVE OPERATION?

_____

_____

Take or recommend action, depending upon you authority. Follow-up: was action effective?

Other Comments: _____

I have investigated this injury and believe it is a complete and accurate account except as follows (Please verify that you have investigated the above accident.)

_____

_____

Signature of Supervisor: _____ **Signature of Department Head:** _____

Date Signed: _____ **Supervisor No.:** _____- _____- _____ **Date Signed:** _____

Revised 01/07/19

PLEASE PRINT LEGIBLY