

Hamilton County School District EMPLOYEE FIRST REPORT OF INJURY OR ILLNESS

**NOTE: NEW REPORTING GUIDELINES THROUGH OUR NEW W/COMP CARRIER - CONTACT FINANCE
REMINDER: Point of Entry for all non-life threatening injuries is the school/site nurse and/or Finance Office**

This form should be completed as soon as possible after injury and sent to Michele Aultman in Finance

****Please call Michele@792-7821 or April@792-7835 ASAP if employee needs to seek immediate treatment**

email: michele.aultman@hamiltonfl.com or april.perez@hamiltonfl.com

Name (First,Middle,Last)	Social Security Number	Date of Accident (M/D/Y)	Time of Accident
Home Address:		Telephone Number(s): Home/Cell	
Date of Birth:	Sex: Male [] Female []	Occupation:	
Employee's Description of Accident (Include cause of injury):			
Injury/Illness that Occurred		Part(s) of Body Affected	
Date First Reported (M/D/Y)	Last Date Employee Worked	Returned to Work () Yes () No If Yes, Give Date _____	
School Site Work Address:		Place of Accident:	
Was Employee Seen by Site Nurse? () Yes - Name/Signature () No		Was Referral made to Health Care Facility/Hospital? () Yes () No If Yes.... () Baya Urgent Care, 1465 W US Hwy 90 Lake City, FL (386) 755-2268 () Other: _____	
<p>Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in s. 817.234, Section 44.0.105(7),F.S. I have reviewed, understand and acknowledge the above statement.</p>			
Employee Signature (If available to sign)		Date	
Employer/Supervisors Signature		Date	
Employer: I agree with description of accident () Yes () No		If No, Explain:	
Name of Witness (if available) _____		Contact Ph# for Witness: _____	