Hamilton County School District

EMPLOYEE FIRST REPORT OF INJURY OR ILLNESS

This form should be completed as soon as possible after injury and faxed to Michele Aultman at 386-792-3681
**Please call Michele at 792-7821 or Mike at 792-7818 ASAP if employee needs to seek treatment at Baya or ER
REMINDER: Point of Entry for all non-life threatening injuries is the school/site nurse.

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: _____

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.

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: _____