Camden County Schools

REPORT OF INJURY OR ILLNESS

Employee Name			DOB		SS#	
Address			State:		Zip	
Phone #	Married	☐ Yes	☐ No	Sex	☐ Male	☐ Female
Job Title:						

Detailed Description of Incident:

Release of Medical Information: *I certify that the above information is true to the best of my knowledge and I authorize the release to my employer and workers' compensation company all records relevant to my disability and my claim for disability or workers' compensation benefits, including but not limited to medical diagnosis, prognosis, treatment, and periods of hospitalization. It is understood that the company will use the information to verify my disability and determine my eligibility of appropriate benefits. This authorization applies to physicians and other health care providers, hospitals, clinics, insurance companies, workers' compensation carriers, and organizations administering benefit programs. This authorization will remain in effect throughout my claim for workers' compensation benefits. I understand that I have the right to revoke this authorization in writing. A photocopy of this authorization will be as valid as the original.*

Employee Signature:	**Date:**

Witness Signature:	**Date:**

Incident Details									
Date of Incident:		Time of Incident:			Date Reported				
Incident Location (area)				On Employer Premise		☐ Yes		☐ No	
First Aid Given?	☐ Yes	☐ No							
Describe Treatment Given Following injury/Exposure:									
Medical Facility:	☐ First Choice Urgent Care (needs authorization form)					☐ ER		☐ None	

Part of Body Injured									
☐ Head		☐ Arm	R L	☐ Trunk	R L	☐ Hip	R L	☐ Foot	R L
☐ Face		☐ Elbow	R L	☐ Shoulder	R L	☐ Thigh	R L	☐ Toe	R L
☐ Eye	R L	☐ Forearm	R L	☐ Chest	R L	☐ Knee	R L	☐ Ribs	R L
☐ Nose		☐ Hand	R L	☐ Back	R L	☐ Leg	R L	☐ Skin	R L
☐ Neck		☐ Finger	R L	☐ Abdomen	R L	☐ Ankle	R L	☐ Other	R L
Other/Description:									

Nature of Injury (mark all that apply)				
☐ Abrasion	☐ Puncture	☐ Chemical	☐ Inhalation	☐ Burn
☐ Bruise/Contusion	☐ Fracture	☐ Hearing	☐ Fatality	☐ Blood/Body Fluid Exposure
☐ Laceration	☐ Poisoning	☐ Sprain	☐ Heat/Cold	☐ Other
☐ Amputation	☐ Dermatitis	☐ Strain	☐ Foreign Object	☐
Other/Description:				

Employee Signature:	**Date:**
Witness Signature:	**Date:**
Nurse Signature:	**Date:**
Principal Signature:	**Date:**

Send report to: **Finance Office**
ATTN: Thad Forehand
331-5610 X 226
tforehand@camden.k12.nc.us