COLQUITT COUNTY BOARD OF EDUCATON
WORKERS' COMPENSATION

FIRST REPORT OF INJURY

DATE _____ CLAIM # _____

NAME OF INJURED _____ SS# _____ AGE _____

ADDRESS OF INJURED _____

CHECK: MARRIED ( ) SINGLE ( ) WIDOWED ( ) DIVORCED ( ) MALE ( ) FEMALE ( )

OCCUPATION OF INJURED _____ DATE OF BIRTH _____

SCHOOL OR LOCATION WHERE ACCIDENT OCCURRED _____

DATE OF INJURY _____ DAY OF WEEK _____ HOUR OF DAY _____

INJURED DID ( ) DID NOT ( ) CONTINUE WORK. DATE DISCONTINUED WORK _____

DESCRIBE FULLY HOW ACCIDENT OCCURRED, NAMING THE MACHINE, TOOL OR THING CAUSING THE INJURY AND STATE WHAT THE EMPLOYEE WAS DOING WHEN INJURED:

_____

_____

_____

NATURE AND LOCATION OF INJURY. (DESCRIBE FULLY THE EXACT LOCATION OF INJURY, RIGHT OR LEFT, ETC.) _____

_____

HAS INJURED RETURED TO WORK? _____ IF SO, DATE _____ HOUR _____

DID EMPLOYEE SEEK MEDICAL ATTENTION? _____ PHYSICIAN _____

NAME OF HOSPITAL _____ PRINCIPAL _____

CENTRAL OFFICE USE ONLY

SALARY _____ ACCIDENT CAUSE _____

HIRE DATE _____ INJURY TYPE _____

NCCI _____ SOURCE CODE _____

CLAIM STATUS _____ BODY LOCATION _____