# NEENAH JOINT SCHOOL DISTRICT
# EMPLOYEE INJURY REPORT

**NAME** ___________________________ **ASSIGNED WORK LOCATION** ____________________________________

**HOME ADDRESS** _______________________________________________________________________________
STREET CITY STATE ZIP

**AGE** _______________ **DATE OF BIRTH** __________________ **SOC SEC #** _____________________________

**HOME PHONE # ( _____ )**_____________________ **DATE OF HIRE** _____________________________________

**SCHEDULED WORK HOURS/DAYS** _______/_______ **JOB TITLE** _______________________________________

## INJURY INFORMATION

**DATE OF INJURY** ___________ **TIME** ____ **AM** ____ **PM** **BODY PART AFFECTED**_____________________

**LOCATION WHERE OCCURRED** __________________________________________________________________

**TYPE OF INJURY** (IE: SPRAIN, STRAIN, FRACTURE, ETC.) ______________________________________________

**HOW DID INJURY OCCUR?** ______________________________________________________________________

**(Continue on back if necessary)** ________________________________________________________________

_________________________________________________________________________________________

**WAS SAFETY EQUIPMENT PROVIDED?** _____ **YES** _____ **NO** **WAS IT USED?** _____ **YES** _____ **NO**

**WITNESSES** ______________________________________________________________________________

**Have you ever had the same or similar condition before?** _____ **Yes** _____ **No** **If YES, explain in detail when, where, and all other circumstance** ______________________________________________________________

_________________________________________________________________________________________

## MEDICAL INFORMATION

**Did you or do you plan on receiving medical treatment of any kind for this injury?** _____ **YES** _____ **NO**

**DOCTOR / HOSPITAL WHERE TREATED**_____________________________________________________________

**ADDRESS** _____________________________________________________ **PHONE #**_____________________

**MISSING TIME FROM WORK?** _____ **YES** _____ **NO** **If YES, Last day worked** ___________________________

**ESTIMATED RETURN TO WORK DATE** ______________________________________________________________

**TO WHOM DID YOU REPORT THIS?** _________________________________ **WHEN** _______________________

**LIST ACTION TAKEN TO PREVENT FUTURE INJURY** ___________________________________________________

_________________________________________________________________________________________

**If you have questions while completing this form call the Payroll & Benefits Office at 751-6800 ext. 10108.**

**AUTHORIZATION**

I, the undersigned, certify that the above information is true and accurate to the best of my knowledge and hereby authorize physicians or practitioners, hospitals, clinics, and other institutes to give my employer, Neenah Joint School District, or the appropriate insurance carrier, any information you have regarding my condition when under observation or treatment by you and to furnish copies of the records when requested by Neenah Joint School District, or appropriate insurance carrier. This information should include history obtained, physical and laboratory findings (x-rays, MRI, electrocardiograms, special tests, etc.) and your conclusions. This authorization is valid as long as a viable workers compensation claim is pending. A photo copy of this authorization may be accepted by you.

**** EMPLOYEE**
**SIGNATURE** _________________________________________ **DATE** ___________________________________

**SUPERVISOR/ADMINISTRATOR**
**SIGNATURE** _________________________________________ **DATE** ___________________________________

**RETURN TO PAYROLL & BENEFITS OFFICE** Revised 02/15