PERQUIMANS COUNTY SCHOOLS
REPORT OF ACCIDENT/INJURY/ILLNESS/

(Must Be Completed immediately after the incident/accident or initial treatment (**NOT LATER THAN 2 BUSINESS DAYS**) and submitted with all other required documents to the Human Resources Department)

SECTION 1: EMPLOYEE INFORMATION (Employee Only)

Employee Name:_____Date of Birth:_____

Home Address:_____City:_____State:_____ Zip code:_____

Home Phone Number_____ Last 4 digits of SSN:_____ Sex: ____F _____M Age:_____

Job Title:_____ School/Department:_____ □ Full Time____□ Part Time _____

SECTION II: ACCIDENT INFORMATION AND EMPLOYEE STATEMENT (Employee Only)

Accident Date:_____Time of Injury:_____ Time Workday Began: _____ □ a.m. □ p.m.

Exact Location of Accident:

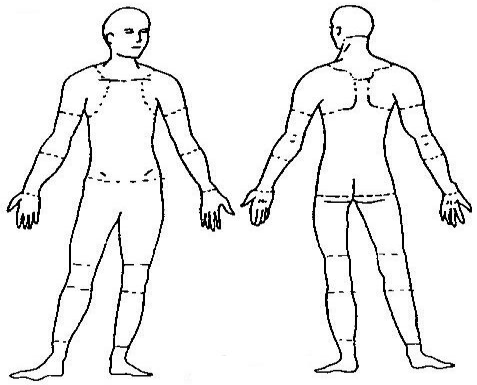
___ Bus # _____
___ Classroom # _____
___ Lunchroom
___ Restroom
___ Other _____
____ Hallway/Building _____
____ Media Center
____ P.E. Class / Gym
____ Play / School Grounds

Witnesses (Names) and (Departments)_____

What was the employee doing just before the accident occurred? Please be very specific :(Describe the activity, as well as the tools, equipment or material the employee was using. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."_____

_____

Body Part affected: (shade injured area)



Full description of how injury occurred. What happened?
Please be very specific :(Tell us how the injury occurred. Examples:
"When ladder slipped on wet floor, worker fell 20 feet";
"Worker was sprayed with chlorine when gasket broke during replacement";
"Worker developed soreness in wrist over time.)

_____

_____

_____

What object or substance caused harm to the employee? _____

_____

What could have been done to prevent this injury/near miss?_____

_____

If the employee died, when did death occur:_____

Was First Aid Given on site? __yes ___no. Describe Aid Given: _____

_____

Was treatment given away from work site? __yes __no.

Doctor (check one):

___NextCare Urgent Care - 615 S. Hughes Blvd, Elizabeth City, NC. Ph. 338-3111
___Family Practice -Dr. Robert Lane - 600 S. Church St., Hertford, NC. Ph. 426-5711

Hospital (Only in case of Emergency)(check one):

___Albemarle Hospital (1144 N. Road St. Elizabeth City, Nc. Ph. 335-0531)
___Chowan Hospital (211 Virginia Road Edenton, Nc. Ph. 482-8451)

Was employee hospitalized overnight as an in-patient? _____yes _____no

Return to work date (as stated by physician) _____

Employee's Statement (Refusal of medical treatment)

I, _____ have been given the opportunity to see a Physician. At this time I do not require medical attention, nor do I want to see a doctor.

I understand that if my condition changes in the near future I do have the right to obtain medical treatment but I also understand that my employer requires me to notify them if I need medical treatment at a later date and they will direct me to the physician that has been selected by my employer to treat workers' compensation injuries.

I further understand that if I seek medical treatment on my own without the approval of my employer I subject myself to having to pay for the medical treatment myself and that the workers' compensation carrier may not pay for my medical treatment under this circumstance.

EMPLOYEE CERTIFICATION

I hereby certify that the above referenced information is true and accurate. I further understand that the information above will be used by my employer to help determine compensability for my injury and that any inaccurate or false statements offered may result in a delay in processing my claim and/or my request for Workers' Compensation Benefits.

Employee Signature_____Date_____

SECTION III: PRINCIPAL/DIRECTOR

This accident was reported to me on: Date:_____ Time:_____ School/Department:_____

Was safety equipment provided? □ Yes □ No □ N/A Was safety equipment used? □ Yes □ No □ N/A

Principal's/Director's Signature:_____
Print Name:_____
Date:_____ Phone#:_____

Case Number from Log Form 300:_____

***Send Original to HR & Copy to District Safety Coordinator**

SECTION IV: HUMAN RESOURCES DEPARTMENT ONLY

Employment Hire Date:_____ Budget Code:_____

Salary:_____ Number of Hours Worked Per Week:_____

Number of days with restrictions: _____

Send Copy to Injured Employee (attach a blank copy of form 18 and copy of form 19) (dates/initial when sent)_____

Filed By Signature_____ Date_____

ATTENTION: This form contains information relating to employee's work-related injury and must be used in a manner that protects the confidentiality of the employee to the maximum extent possible.