EMPLOYEE'S FIRST REPORT OF INJURY OR ILLNESS

SUBMIT TO WORKERS' COMPENSATION OFFICE WITHIN 24 HOURS OF INCIDENT.

FAX: 972-968-6103 or email workerscompensation@cfbisd.edu

Debra Kilgore(Workers' Comp Specialist) 972-968-6199 or Jessica O'Leary 972-968-6120

Name: ______________________________ **Occupation**______________________________ **SSN:** __________________

Female: __ **Male:** __ **D.O.B.** __________ **Hire Date:** ________ **Home Phone:** ___________**EMP ID:**___________

Permission to correspond by email? Yes:____ **No:**_____ **Email:** ____

Primary Language: English _____ **Spanish**___ **Vietnamese**___ **Cambodian**___ **Other**_________________________

Ethnicity: American Indian/Alaska Native____ **Asian** _____ **Black/African American** _____

Hispanic/Latino _____ **Native Hawaiian/Other Pacific Islander** ______ **White** _____**Other** ____________

Employee's Mailing Address: ____
Street or P.O. Box

____
City **State** **ZIP Code** **COUNTY**

Marital Status: ______ **Number of Dependent Children:** _______ **Spouse's Name:**_______________________________

Date of Injury: _________ **Time of Injury:** __________**A.M./P.M. Performing normal job? Yes**___ **No**____

Missed Work? Yes___ **No**___ **Dates missed:** ____________________ **Date returned to work:**____________

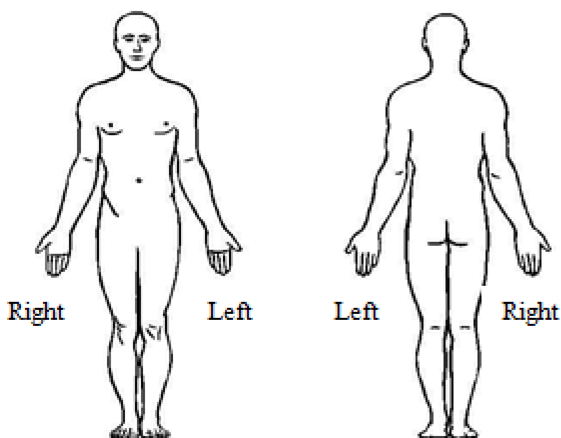
If an employee is injured as the result of a physical assault during the performance of their duties, as defined in the District Policies-DEC (Legal), assault leave may be requested. An investigation of the incident will be conducted to confirm or deny assault leave status. **Do you wish to file for Assault Leave? Yes ___No ___Not Applicable_______**

Where did injury occur? ____ _____________________________________
Campus **Injury site (classroom, gym, office, etc.)**

Explanation of how injury occurred: ____

____

Witnesses**:** ____
____



Statement of body parts injured (Example: upper left arm):

____

Does injury require medical examination? Yes___ **No**____

- **Please contact the WC office PRIOR to examination for authorization.**
- **Please note that seeing a non-workers' compensation approved physician may result in non-refundable medical expenses.**

WC OFFICE USE ONLY: I.O.____ **M.O.**____ **Indemnity**___

Body Part(s) Injured (circle all that apply)

Employee's Signature______________________________________ **Date**____________________

Supervisor's Signature_____________________________________ **Date Injury Reported** _________**Time**_______**A.M./P.M.**

Revised 6/2017 dk