EMPLOYEE STATEMENT OF INJURY OR ACCIDENT

CADDO PARISH SCHOOL BOARD
Risk Management

NOTE: THIS FORM MUST BE COMPLETED BY THE <u>EMPLOYEE</u> ONLY.

EMPLOYEE INFORMATION

EMPLOYEE NAME *(Last, First, Middle)*			TELEPHONE NUMBER	
SCHOOL/DEPARTMENT			DATE OF HIRE	
JOB TITLE	☐ FULL-TIME ☐ PART-TIME	NAME OF SUPERVISOR/MANAGER		
EMPLOYEE ADDRESS (Street)				
(City)			(State)	(Zip Code)
SOCIAL SECURITY NUMBER	DATE OF BIRTH	MARITAL STATUS	RACE	☐ MALE ☐ FEMALE

ACCIDENT/INJURY INFORMATION

DATE OF INJURY OR ILLNESS	TIME OF INJURY OR ILLNESS	☐ AM ☐ PM	DID INJURY/ACCIDENT OCCUR OCCUR AT A CPSB PROPERTY? ☐ YES ☐ NO
IF SO, NAME OF SCHOOL/DEPARTMENT	LOCATION AT SCHOOL *(Be specific)*		
DATE EMPLOYER NOTIFIED OF INJURY/ILLNESS	TIME EMPLOYER NOTIFIED OF INJURY/ILLNESS	☐ AM ☐ PM	
NAME OF PERSON INJURY/ILLNESS REPORTED TO	WAS THE INJURY/ILLNESS REPORTED VERBALLY OR IN WRITING?		
DESCRIBE THE SPECIFIC ACTIVITY YOU WERE ENGAGED IN AT THE TIME OF THE ACCIDENT OR ILLNESS			
LIST ALL EQUIPMENT, MATERIALS AND CHEMICALS THAT WERE BEING USED AT THE TIME OF THE ACCIDENT OR ILLNESS			
HOW DID THE ACCIDENT/INJURY OCCUR? *(Be specific)*			
NAME AND TELEPHONE NUMBER OF ALL WITNESSES			
DESCRIBE ALL BODY PART(S) THAT WERE INJURED	DESCRIBE TYPE OF INJURY TO EACH BODY PART LISTED		
DATE EMPLOYEE RETURNED TO WORK	IF YOU MISSED TIME FROM WORK, PROVIDE DATES		
NAME AND ADDRESS OF ALL MEDICAL CARE PROVIDERS AND/OR FACILITIES WHERE YOU HAVE RECEIVED MEDICAL CARE			

I UNDERSTAND THAT IT IS UNLAWFUL TO MAKE A FALSE STATEMENT OR REPRESENTATION IN ORDER TO OBTAIN WORKERS' COMPENSATION BENEFITS. I UNDERSTAND THAT MY FAILURE TO ANSWER ANY OF THE ABOVE QUESTIONS TRUTHFULLY MAY RESULT IN MY FORFEITURE OF ANY AND ALL WORKERS' COMPENSATION BENEFITS UNDER LA. REV. STAT. ANN. § 23:1208.

_____ _____
Employee Signature Date

Principals/Supervisors/Managers shall submit to Risk Management with the mandated First Report of Injury or Illness within 24 hours of the accident or on notice of the injury/illness.

RM-4 7/15