WINSTON SALEM/ FORSYTH COUNTY SCHOOLS
EMPLOYEE REPORT OF
ON THE JOB INJURY

All Information must be completed by the Injured Worker the day of the accident
If Injured Worker unable to complete, Supervisor may complete on his behalf
Fax completed form to the Workers' Comp office at 336.661.6536

Employee Name: _____ Phone: _____SSN: XXX-XX-_____

Address: _____City: _____St: ____ZIP_____

Date of Injury: _____ Time of Injury: _____ School/Office_____

Location where injury occurred: _____

What time of day did employee start work on date of injury: _____?

Employee Job Title: _____

Name of Witness(es)_____Witness Position/Title_____

Employee description of how injury occurred: _____

_____

_____

_____

_____

(Continue on back of form if more space is necessary.)

List all injuries and specific body parts (i.e., cut on right hand, left foot): _____

Is employee expected to miss time from work as a result of the injury? _____

Medical Treatment? (Circle one) Yes No Which **Novant Health Occupational Medicine** location?

Circle one: Novant Health Occupational Medicine (2337 Winterhaven Lane, W-S 27103) Novant Health Occupational Medicine (501 Hickory Branch Drive, Greensboro 27409)

Name of supervisor_____ Date and time he/she was notified: _____

_____ _____

Employee Signature Date Supervisor Signature Date

Name of Person Completing this Form: _____Position/Title_____

Witness statements should be forwarded to WSFCS WorkersCompensation@wsfcs.k12.nc.us within 24 hours of initial report

Failure to comply with WSFCS Worker's Comp Procedures could cause a delay in receiving benefits or a denial of your claim.