PERTH AMBOY BOARD OF EDUCATION

WORKERS' COMPENSATION INCIDENT REPORT

EMPLOYEE

Incident Date: _____ Time of Incident: _____ Report Date: _____

How Reported: ☐ Phone ☐ In Person ☐ Other: _____

Name: _____ DOB: _____

Address: _____ Phone #:_____

---------- **INCIDENT INFORMATION** ----------

School: _____

Exact Location of Incident: _____

Description of Incident/Injury:_____

_____

_____

Witness of Incident: _____

Investigation of Incident: _____

_____

Investigation Completed By: _____

Treatment of Injury by: ☐ School Nurse Only ☐ Doctor/Hospital/Medical Center ☐ None

Treatment Given On-Site: _____

_____

Recommended Corrective Action: _____

_____

_____ _____

Nurse Principal/Administrator/Supervisor

_____ _____

Date Date

White Copy: Benefits Coordinator **Yellow Copy: School Nurse** **Pink Copy: Principal**