**Hall County Board of Education - Employee Injury Report Form**

Fill in **ALL** information and return to the business office within (3) working days of the injury.

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| --- | --- | --- | --- |
| Name |  | Social Security # |  |
| Address |  |
| City |  | State |  | Zip |  |
| Home Phone # |  | Age |  | DOB |  | Sex |  Male [ ]  |  Female [ ]  |
| Job Title |  | Supervisor |  |
| Work Location |  | Injury Date | Click or tap to enter a date. | Time of Injury |  | AM |
|  |  |  |  |  |  | PM |
| Time Workday Began |  | AM | Date Employer Notified | Click or tap to enter a date. | Time Employer Notified |  | AM |
|  |  | PM |  |  |  |  | PM |
| Full-Time |[ ]  Number of hours worked per day |  | Number of hours worked per Week |  |
| Part-Time |[ ]   |  |  |  |
| Is this a re-injury to, or an aggravation of, a previous medical condition? | Yes |[ ]  No |[ ]
| If yes, please explain |  |
| Describe how and where the accident occurred (be specific) |  |
| What part of the body was injured? |  | Did anyone witness this injury? | Yes |[ ]  No |[ ]
| If yes, please list the name of the witness |  | Witness work location |  |
| Did injury develop gradually? | Yes |[ ]  No |[ ]  If yes, list dates | FROM | Click or tap to enter a date. | TO | Click or tap to enter a date. |
| Describe how the injury developed |  |
| By typing my name in the signature section below I certify the above is an accurate description of the accident and the injury I sustained while I was working for the Hall County Board of Education. I understand that if I need medical attention for this injury I must select a physician from the posted panel. Should my injury / illness prove to be non-related to my employment I will be responsible for any medical bills incurred. |

|  |  |  |  |
| --- | --- | --- | --- |
| Employee’s Signature |  | Date | Click or tap to enter a date. |