**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.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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