RUMSON SCHOOL DISTRICT
EMPLOYEE ACCIDENT FORM

Name:	Report Date:	Report Time:

DETAILS OF ACCIDENT

Date of accident: _____ Time of accident: _____

Location:_____

Witnesses:_____

Describe what happened:_____

_____

_____

_____

_____

DETAILS OF INJURY

Nature of injury (cut, abrasion, pain, etc): _____

What Part(s) of the body were hurt and in what part(s) of the body do you feel pain?:

_____

Have you had treatment in the past for the same or similar medical condition? Yes / No

If yes, please provide the name and address of the treating physician(s) for this condition. List any medications you are or were taking for this condition/injury?

_____

Have you been treated in the past by a chiropractor(s)? Yes / No

If yes, please provide the name and address of the chiropractor(s)?
_____

Have you filed any Workers' Compensation claim(s) in the past for this medical condition?
Yes / No
If yes please provide the details of the previous claim(s).
_____

Have you ever been involved in any motor vehicle collisions? Yes / No
If yes please provide the details of the crash, date, and the nature of the injury and treatment.
_____

Are you currently engaged in any other employment or have you ever been engaged in any other employment while you were employed by us? Yes / No

If yes , please list the names and addresses of these employers
_____.

Do you currently(in the past 12 months) participate in any athletic, recreational or sporting activities? Yes / No

If yes , Please list the activities you participate in.
_____

Have you ever received pain management treatment? If so, by whom?_____
_____

To whom did you first report the injury to and when?_____

_____

I CERTIFY THAT THE ABOVE STATEMENTS MADE BY ME ARE TRUE AND CORRECT. I AM AWARE THAT IF ANY OF THE STATEMENTS ARE WILLFULLY FALSE, I MAY BE SUBJECT TO DISCIPLINARY ACTION BY MY EMPLOYER.

X_____ X_____MM/DD/YYYY_____
Employee Signature Supervisor's Signature Date

Treatment of injury:_____

_____

_____

Treatment administered by :

_____

FOLLOW UP

Did employee return to work following accident? Yes / No

If no, where did employee go? ER _____ / Workmans Comp MD / Home

Was Workmans Comp info given to employee? Yes / No and by whom?

_____

Was Rx info for Workmans Comp given to employee? Yes / No and by whom?

_____

Employee Signature:_____Date:_____

School Nurse:_____Date:_____

School Admin:_____Date:_____

Supt./BA:_____Date:_____

Additional Notes:

Rumson School District Employees

Qual-Lynx Workers' Compensation

If you get hurt on the job tell your employer immediately and call 1-800-425-3222
DO NOT GO TO YOUR OWN PRIVATE DOCTOR OR CHIROPRACTOR.

In Case of Emergency, go to the nearest hospital and tell your employer and Qual-Lynx within 24 hours.

Source4Teachers Mission One Employees

S4T Workers' Compensation To report an injury call 1-844-482-9200