CORRY AREA SCHOOL DISTRICT

WORK RELATED INCIDENT REPORT

EMPLOYER'S NAME:	CORRY AREA SCHOOL DISTRICT	**TAX ID:** 25-1215002	**POLICY** #Q91-5103060
EMPLOYER'S ADDRESS:	540 E PLEASANT ST CORRY PA 16407		**COUNTY:** ERIE
REPORT FILED BY:		**PHONE:** **1-814-664-4677**	**X**

SECTION I: EMPLOYEE INFORMATION

LAST NAME:		**FIRST NAME:**		**MI:**
HOME ADDRESS:			**# OF DEPENDENTS:**	
CITY:	**STATE:**	**ZIP:**	**COUNTY:**	
HOME PHONE:	**GENDER:** **M** **F**		**MARITAL STATUS:**	
SS #:	**DATE OF BIRTH:**		**DATE OF HIRE:**	
JOB TITLE:	**HOURS/WEEK WORKED:**		**TIME SHIFT STARTS:**	
WORKS: Part-time Full-time	**WAGE INFORMATION:** **$**		Hourly Bi-Weekly (circle one)	

SECTION II: INCIDENT INFORMATION

DATE OF INCIDENT:	**TIME OF INCIDENT:**	**INJURED BODY PART:**	
LOCATION OF INCIDENT (Building Name ie., CAIS, CAPS MHS)**:**			
LOCATION ADDRESS:		**TYPE OF INJURY** (cut, sprain, etc.)**:**	
CITY:	**STATE:**	**ZIP:**	**COUNTY:**
CAUSE OF INJURY (machine, tool, etc.)**:**			
DATE REPORTED:	**TO WHOM REPORTED:**		
WAS THERE A WITNESS? Y N	**NAME(S) OF WITNESS(ES):**		

DESCRIPTION OF INCIDENT (describe in detail what happened): _____

SECTION III: TREATMENT

_____ No Medical Treatment

_____ Minor on-site remedies by Employer Medical Staff

_____ Sent Home

_____ Returned to work with Modified Duties

Note Modifications: _____

_____ Medical Treatment Sought

Provide all dates absent from work for medical treatment due to this incident:

_____

_____

EMPLOYEE & SUPERVISOR SIGNATURES ARE REQUIRED ON PAGE 2

SECTION IV: MEDICAL AUTHORIZATION - EMPLOYEE SIGNATURE REQUIRED

I, the undersigned, hereby authorize any medical care provider who has treated me, or any hospital to which I have been admitted, to furnish to any authroized representative of AmTrust North America, any and all information which may be requested regarding my physical condition, treatment or disease, and if necessary to allow them or any physician appointed by them to review any X-rays or records regarding my physical condition or treatment.

Employee's Signature: _____ Date: _____

SECTION V: SIGNATURES REQUIRED

I have received the panel of physicans and understand that if I need to seek treatment for this incident, I am to use a physician from that panel.

Employee's Signature: _____ Date: _____

I am aware of and have reviewed this work related incident.

Supervisor's Signature: _____ Date: _____

SECTION VI: MEDICAL TREATMENT BY PANEL PHYSICIAN

If medical treatment is sought, please send a COPY of this report to the Admin office. Take the original form to your appointment with the panel approved physician to complete this section. Then turn in the original to Admin Office.

TYPE OF INJURY: _____

TREATMENT/FIRST AID DIAGNOSIS: _____

DISPOSITION: _____

_____ **Return to work without limitations**

_____ **Return to work with limitations:** Note limitations: _____

_____

RETURN TO WORK ON: _____ **FOLLOW-UP APPOINTMENT ON:** _____

Name of Panel Physician seen (Please Print): _____

Signature of Panel Physician: _____ Date: _____

*****ALL INCIDENTS ARE TO BE REPORTED*****

1. In life threatening situations, immediately seek medical attention, then complete this form.
2. Report incident as soon as possible to your supervisor.
3. Complete this form and turn into your supervisor.
4. Completed forms, signed off by supervisor, are to be sent to the Business Manager in the Administration Office.
5. If seeking medical attention, please be sure to see a panel physician.

CASD Worker's Compensation insurance company is:
Erie Insurance
100 Erie Insurance Place
Erie PA 16530
Phone: 1-855-492-3665 Fax: 1-855-792-3665

FOR BUSINESS MANAGER ONLY

Investigation Notes: _____

_____

_____

Investigating Officer's Signature: _____ Date: _____

Business Manager's Signature: _____ Date: _____