MAISL WORKERS COMPENSATION FUND
EMPLOYEE INJURY/ACCIDENT REPORT FORM

Please print clearly and complete all sections of the accident report. Please also follow these instructions:

1. Injured employee notifies the building principal or secretary.
2. Injured employee completes Employee Injury/Accident Report (provided by building principal/secretary).
3. Building principal/secretary contacts HR at x1663 to advise of injury and advise if injured employee is going to clinic.
4. Building principal/secretary faxes Employee Injury/Accident Report to x1611.
5. Building principal/secretary sends original Employee Injury/Accident Report to HR through interoffice mail.
6. **Injured Employee returns to the HR office with Clinic paperwork prior to returning to assignment.**

Social Security Number	Date of Injury	Time of Injury AM PM	Employee Name (Last, First, MI)
Employee Home Address			City, State, Zip Code
Date of Birth	Sex (Circle One) M F	Telephone Number ( ) Home ( ) Cell	☐ Single ☐ Married ☐ Number of Dependents
What was the employee doing just before the accident occurred? (Be specific)			
Describe the Events Which Caused Your Injury (Example: Fell, Operations, Injury):			
Was there an unsafe condition that caused the injury? (check one): ☐ Yes ☐ No If yes, please list the unsafe condition that caused the injury:			
Describe the Nature of the Injury or Illness (Example: Amputation, Burn, Cut, Fracture):			
Part of the Body Directly Affected By Your Injury or Illness (Example: Hand, Arm):			
What object/substance directly harmed the employee? (Example: Knife, Acid, Floor, Oil)			
What could have been done to prevent the injury?			
Were proper procedures being followed when accident occurred? (check one) ☐ Yes ☐ No If no, explain:			
Medical Treatment Required? ☐ None ☐ First Aid ☐ Sent to Clinic ☐ Doctor or Hospital Name:			
Your Position (Teacher, Secretary, Security, etc.)	Building Where You Work (Address) Wayne County		Shift Start Time AM PM
Today's Date	Your Signature (A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony. I hereby declare that the facts stated above are true.)		
List All Witnesses with their contact number:			
Signature of Principal/Supervisor:			Date

FOR PERSONNEL OFFICE USE BELOW

Date of Verbal Report of Injury to Personnel Office:	
Date Received in Personnel Office:	☐ Sent to Clinic ☐ Incident Only
Last Day Worked:	Date Returned to Work: