EMPLOYEE'S REPORT OF INJURY

ATTENTION EMPLOYEE: SDCL 62-4-51 provides that any person who knowingly files a fraudulent claim for worker's compensation benefits is guilty of a Class 1 misdemeanor.

ACCIDENT INFORMATION

1. NAME OF SCHOOL DISTRICT:

2. NAME : LAST FIRST M.I.

3. WHAT HAPPENED? (If a diagram drawing helps, draw on the back of the form)

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4. NAMES OF WITNESSES: (Persons present at the time of injury)

5. LOCATION OF ACCIDENT:

6. HOW WERE YOU HURT?

7. WHAT IS YOUR INJURY?

8. DATE OF INJURY:

9. TIME OF INJURY: ___________ AM ___________ PM

10. DID YOU SEEK MEDICAL ATTENTION? YES________ NO________

11. PHYSICIAN'S NAME, ADDRESS, AND TELEPHONE:

12. HOSPITAL OR CLINIC NAME, ADDRESS, AND TELEPHONE:

13. WHO ACCOMPANIED YOU TO THE HOSPITAL OR CLINIC?

NAME: ____

A SCHOOL DISTRICT EMPLOYEE? YES_______ NO_______

14. DATE REPORT RECEIVED AND NAME OF PERSON RECEIVING REPORT:

(When this form is sent to the ASBSD, it must be accompanied by the Employer's First Report of Injury)