DOUGLAS COUNTY SCHOOL DISTRICT
HUMAN RESOURCES
620 Wilcox Street Castle Rock, CO 80104
Ph 720-433-1087 / Cell 303-495-4783 / tj.crawford@dcsdk12.org

EMPLOYEE INJURY/ILLNESS REPORT FORM

COMPLETE THIS FORM ENTIRELY (FRONT AND BACK) FOR ANY WORK RELATED INJURY, THEN FORWARD TO HUMAN RESOURCES WITHIN 24 HOURS.

SECTION 1: TO BE COMPLETED BY EMPLOYEE

Employee's Name: (First, Middle, Last)

Home Address (not Post Office Box please)

City/State/Zip

Date of Hire | Job Title

Do you currently have health insurance benefits through the District? Yes ☐ No ☐

Do you currently have vision benefits through the District? Yes ☐ No ☐

Do you currently have dental benefits through the District Yes ☐ No ☐

Were you performing your regular job assignment at the time of injury? Yes ☐ No ☐ If no, what was your assigned job at the time of injury?

Social Security #

Home Phone or Cell Number | Work Phone Number

Age | Date of Birth | Male/Female | Martial Status

Work Hours | Days (M-F) | Length of Experience

Do you currently hold a second job? Yes ☐ No ☐

If so, where?_____

What is your job title and what are your duties for your second position?

_____

What is you hourly wage for the second position? _____

What are the average hours per week worked at the second job? _____

Injury Information

Date of Injury _____

Time _____ AM ☐ PM ☐

Time Employee began work

Time _____ AM ☐ PM ☐

Address where injury occurred:

Building_____

Street Address_____

City and zip code_____

Site of Injury : Cafeteria ☐ | Classroom ☐ | Corridor/Hall ☐ | Gymnasium ☐ | Playground ☐ | School Ground ☐ | Other/where?

What is the body part injured?

What is the nature of the injury?

What was the employee doing just before the accident occurred?

How did injury happen?

What object or substance directly harmed employee?

Who did you first report this to?

Please list any witnesses:

Do you feel you need medical attention? Yes ☐ No ☐ If no, please date and initial here _____

I understand it is unlawful to make fraudulent claims. Any person who makes or causes to be made, any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying Workers' Compensation benefits or payments is guilty of a felony and may be prosecuted.

Signature of Employee _____ Date:_____

Note: If medical treatment is needed, you must contact Workers' Compensation immediately at 720-433-1087 for an appointment with a designated treating physician. Failure to do so could result in non-payment of bills and loss of benefits.

For lost time claims (after three shifts of missed work) work comp covers 2/3 of your wages up to a State maximum allowable amount. It is the District's practice to cover the other 1/3 wages by reducing the employee's accrued sick or teacher leave. If this not agreeable to you, please initial here: _____Date:_____

SECTION 2: TO BE COMPLETED BY SUPERVISOR

Was employee able to continue working? Yes ☐ No ☐ **W**hat was employee doing at the time of the injury? (Be specific – if using tools or handling material, name them and tell how they were being used)

_____

Injury occurred because of : Intoxication ☐ Safety Violation ☐ Not Applicable ☐

Based upon the injury description provided by the employee, please describe any unsafe acts or unsafe conditions:

_____

Suggested corrective action (what has been done or what do you recommend to prevent a similar injury?)

_____

Please note: signing this injury report confirms that you have reviewed all the facts contained in this report.

Signature of Supervisor_____ Date: _____

THE INJURED EMPLOYEE MUST COMPLETE THE OTHER SIDE OF THIS FORM

Medical Release – It is required that you complete the boxes highlighted in GREY below.

From time to time it is necessary to receive previous medical records prior to making a determination of liability. Please read and sign the

following medical records release. In addition, immediately below the release please list any and all medical providers you have seen in the past five (5) years. Thank you for your cooperation.

Release From (For Providers Only): Address:	**Claimant name:** **SS#:** **Date of Birth:**	Release To: Douglas County School District 620 Wilcox St. Castle Rock, CO 80104 Attn: Human Resources & CCMSI P.O. Box 4998 Greenwood Village, CO 80155

I authorize the above named health care provider to release the information specified below to the organization, agency or individual named on this request. I specifically authorize the release of all medical information, including the following specific conditions:

Drug abuse* ☒ Alcohol abuse* ☒ Psychological or psychiatric condition ☒ Sickle cell anemia ☒

*Alcohol or drug abuse statement must be attached to any disclosure of this information from a federally assisted alcohol or drug abuse program. Any oral disclosure shall be accompanied or followed by such statement.

Information Requested:	Condition(s) and Dates of Care Requested:
☒ Copy of history and physical, discharge summary and operative reports ☒ Copy of outpatient and ER admissions ☒ Narrative reports ☒ Copy of expenses, bills and statements ☒ Other (specify) _____	All past admissions or care at this facility ☒ Limited to treatment dates and conditions described below: _____ _____ _____ _____

Purposes or need for which this information is to be used:
☒ Injury or claim evaluation ☒ Workers' Compensation ☒ Other:_____

EXPIRATION OR REVOCATION OF AUTHORIZATION – I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my previous express revocation, this authorization will automatically expire.

☒ *Upon fulfilling the purpose or need for information as specified above, but no longer than 360 days from the date of signature.

*Note: Federal regulations require that consent to release alcohol or drug records last no longer than reasonably necessary to serve the purpose for which the release is given.

Use of Copies: A copy of this authorization with my signature thereon: ☒ May be utilized with the same effectiveness as an original.

Signature of Patient:	**Date:**
Person authorized to sign for patient: _____ **Relationship:**	

Please list your medical providers for the last 8 years

Provider	Complete Mailing Address and Phone #
Provider	Complete Mailing Address and Phone #
Provider	Complete Mailing Address and Phone #
Provider	Complete Mailing Address and Phone #