Worker's Compensation
Follow Up to Injury

Please complete this report within 7 days of your injury/illness. This form will need to be completed in its entirety and forwarded to the district office, attention benefits department. This is a supplement report and will be used ONLY as a follow up and not a determination of benefits and/or closure.

Employee's Name: _____

Job Title: _____

Date of Injury or illness: _____

1. Was this a minor injury with no treatment necessary, or minor first aide administered by the school (if yes, skip to signature)?

   _____Yes _____No

2. Was medication prescribed by physician?

   _____Yes _____No

3. Has this injury resulted in a job transfer or other job restriction?

   _____Yes _____No

   If yes, list # days _____ or,
   Approximate date of return to normal duties:_____

4. Has this injury resulted in days away from work?

   _____Yes _____No

   If yes, list # days _____ or,
   Approximate date of return:_____

5. Are you still seeking medical treatment/care for this injury/illness?

   _____Yes _____ No

Employee Signature: _____

Date: _____