**Forsyth County Employee Injury/Illness Report**

**Claim #:**

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| **Employee must check one of these boxes:** [ ]  I do not wish to file a workers’ compensation claim. This is an incident report only and I am not seeking medical treatment. [ ]  By signing this form I acknowledge that I am filing a workers’ compensation claim with Forsyth County. I acknowledge that filing this workers’ compensation claim does not guarantee coverage by Forsyth County or its third party administrator. I acknowledge the facts stated in this form are the truth to the best of my knowledge.  |

The employee shall notify the supervisor and complete this report immediately after a work-related injury/illness. The supervisor shall notify Risk Management by calling 703-2058 or 703-2057 as soon as they learn of the injury. **Scan and** e**mail the completed report to:** **everhatg@forsyth.cc** **or** **sorianm2@forsyth.cc** **or fax it to: 336-727-8045.**

**Reports must be received by Risk Management on the day of or within 24 hours of the incident.**

**To be completed ONLY by the employee. Answer all questions. Sign & submit to your supervisor.**

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| **Incident Report** |
| Date of Report:        | Date of Injury:       | Time of Injury:       [ ] AM [ ] PM | Time Employee began work:       [ ] AM [ ] PM  |
| Employee was working an: [ ]  8 hour shift [ ]  12 hour shift [ ]  24 hour shift  | # Hours worked before the injury:      |
| This incident occurred during what part of your workday?[ ]  Entering or Leaving Work [ ]  Performing Normal Activities [ ]  During Meal Period [ ]  During Break  |
| Date Employer Notified:      | Date Returned to Work:        | Time Returned to Work After Injury:       [ ]  AM [ ]  PM |

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| **Incident Occurrence** |
| Did it occur on county property? [ ]  Yes [ ]  No  | Name of location where the incident occurred:       | Street Address:      City:       Zip:       |
| Type of foot wear worn:[ ]  Flat [ ]  Wedge [ ]  Heel [ ]  Sandal [ ]  Boot [ ]  Leather sole [ ]  Rubber sole [ ]  Safety footwear |
| Precise location where injury occurred:       |

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| **Injured Employee Information** |
| First Name:       | M.I.      | Last Name:       | Home Phone:       | Cell Phone:      |
| Home Address:       | City:       | County:       | Zip:      |
| Date of Birth:       | Age:       | Sex:       | # of Dependents:       |
| Marital Status: [ ]  Married [ ]  Unmarried [ ]  Widowed [ ]  Divorced [ ]  Separated |

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| **Employment Information** |
| Department Name:        | Division Name:       | Job Title:       | Date of Hire:       |
| Work Phone:      | Work Cell:      | Employee’s Work Email:      |
| # of Days Work per Week:       | # of Hours Work per Day:       | # of Hours Work per Week:       |
| Supervisor’s Name:       | Supervisor’s Cell:       | Supervisor’s Phone:       |

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| **Nature of the Injury/Illness. Check the most serious one:** |
| [ ]  Abrasion, scrape, scratch [ ]  Amputation[ ]  Animal bite[ ]  Broken bone[ ]  Bruise/Contusion[ ]  Burn (chemical)[ ]  Burn (heat)[ ]  Concussion (to head) [ ]  Crushing injury | [ ]  Cut, laceration, puncture[ ]  Dermatitis/Rash[ ]  Exposure (bodily fluid, bio hazard)[ ]  Hernia[ ]  Illness[ ]  Insect bite[ ]  Sprain, strain[ ]  Other: Describe:       |

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| **State specifically what task was being performed when the incident occurred:** **:** |
|       |
| **Describe the circumstances causing the injury. Be specific about the cause.****:** |
|       |

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| **Choose factor(s) which directly or indirectly caused the incident to occur:****:** |
| [ ]  Action of other person[ ]  Assault by other [ ]  Blood/Bodily fluid exposure[ ]  Caught in/Under/Between object[ ]  Distracted/Inattention/Shortcuts[ ]  Electric Shock | [ ]  Fall[ ]  Fatigue[ ]  Faulty equipment[ ]  Lifting[ ]  Repetitive motion[ ]  Rubbed or abraded by object  | [ ]  Struck against object[ ]  Struck by object[ ]  Temperature extremes[ ]  Vehicle/Equipment accident[ ]  Other – Describe:       |

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| **Check the specific body part(s) affected** |
| **Body Part** | **Left Side** | **Right Side** | **Both Sides** | **Upper** | **Lower** | **Front** | **Back** | **Body Part** | **Left Side** | **Right Side** | **Both Sides** | **Upper** | **Lower** | **Front** | **Back** |
| **Abdomen** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | **Head** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Ankle** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | **Heel** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Arm** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | **Hip** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Back** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | **Knee** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Buttock** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | **Leg** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Cheek** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | **Neck** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Chest** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | **Nose** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Chin** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | **Rib** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Ear** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | **Scalp** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Elbow** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | **Skin** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Eye** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | **Skull** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Face** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | **Shoulder** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Finger(s)** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | **Thigh** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Foot** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | **Toe(s)** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Forehead** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | **Wrist** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Hand** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | **Other:**  |  |

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| **Medical Care / Treatment** |
| [ ]  Declined medical treatment [ ]  First aid by employer [ ]  Treated at WFBH Winston East OccMed Clinic [ ]  Name of medical facility other than WFBH Winston East:       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  WFBH Emergency Department [ ]  Hospitalized > 24 hours  |
| Date Treatment Received:       | Time:      [ ]  AM [ ]  PM  | Name of Treating Physician:       |
| Transported by: [ ]  Self [ ]  Ambulance [ ]  Other – Describe:       |

**Employee’s Signature:**      **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:**

**Supervisor’s Signature:**      **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:**