**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**](mailto:everhatg@forsyth.cc) **or** [**sorianm2@forsyth.cc**](mailto: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:**  **:** |
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| **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:**