Work-Related Incident Report – School Claims Service, LLC

Section One: Employee and Incident Information

SCHOOL DISTRICT NAME (NO ABBREVIATIONS):	SCHOOL DISTRICT ADDRESS:	County:

Employee name (last, first, middle initial):	Home phone:	Gender: M F	Marital status: M S Dep.

Home address (street, city, state, zip):	County:

SS #:	Date of birth:	Date of incident:	Time of incident:	Date reported:	To whom reported:

Location of incident (building, room, etc.):	Type of injury (cut, sprain, etc.):

Injured body part:	Cause of injury (machine, tool, etc.):

Employee's job title:	Date of hire:	Hours worked per week:	Time shift starts:

Description of incident (please describe in detail what happened):

Name of supervisor: _____

Section Two: Medical Authorization

I, the undersigned, hereby authorize any medical care provider who has treated me, or any hospital to which I have been admitted, to furnish to any authorized representative of School Claims Service, LLC, any and all information which may be requested regarding my physical condition, treatment or disease, and if necessary, to allow them or any physician appointed by them to review any X-rays or records, regarding my physical condition or treatment.

Employee's signature: _____ Date: _____

Section Three: For Use of School District's Workers' Compensation Coordinator

TYPE OF CLAIM: ❑ Notice Only (No Medical Treatment) ❑ Medical Only ❑ Lost time/Last date worked ___/___/___

NAME OF W/C COORDINATOR: _____ Phone: _____ Ext.: _____

Section Four: Medical Treatment

Type of Injury: _____ ❑ New ❑ Other (describe): _____
Treatment/first aid: _____
Diagnosis: _____
Disposition: _____
❑ Return to work without limitations
❑ Return to work with noted limitations (describe): _____
❑ May return to work on _____/_____/_____
❑ Followup appointment with: _____ on _____/_____/_____
Signature of medical/first aid provider: _____ Date _____
Address: _____

School Claims Service, LLC
P.O. Box 813
New Cumberland, PA 17070-0813
Tel: (866) 402-6600 Fax: (866) 402-6601

FAX TO SCHOOL CLAIMS SERVICE, LLC WITHIN 24 HOURS OF INJURY