Seguin ISD Workers' Compensation Program
Employee's First Report of Injury Illness

1. EMPLOYEE'S LAST NAME:	1a. FIRST NAME:	1b. MI:	15. EMPLOYEE'S DEPARTMENT and FACILITY (campus):	16. SUPERVISOR'S NAME:
2. EMPLOYE'S MAILING ADDRESS: (street or PO Box)			17. KIND/TYPE of INJURY:	18. BODY PART(s) INJURED:
2a. CITY:	2b. STATE:	2c. ZIP CODE:	19. CAUSE of INJURY (i.e. fall, tool, machine, tripped & fell, etc.)	20. WORKSITE LOCATION of INJURY: (i.e. stairs, dock, kitchen, hallway, etc.)
3. PHONE + AREA CODE HM:_____ Alt: _____	4. DATE of BIRTH:	5. EMPLOYEE's SS#: SS:_____	21. EXPLAIN HOW and WHY INJURY or ILLNESS OCCURRED:	
6. GENDER (•) Female ( ) Male	7. EMPLOYEE'S MARITAL STATUS: (•) Married ( ) Widow ( ) Separated ( ) Divorced ( ) Single			
8. Does Employee SPEAK ENGLISH? (•) Yes ( ) No	8a. If No, what LANGUAGE is SPOKEN?		22. WAS EMPLOYEE DOING HIS/HER JOB? (•) Yes ( ) No	23. LIST EQUIPMENT USED:
9. EMPLOYEE'S JOB TITLE (position):	10. NUMBER of DEPENDENT CHILDREN:			
11. PLEASE MARK WHERE APPLICABLE: (•) RECORD ONLY ( ) MEDICAL ( ) LOST TIME (only by order of doctor)			24. NAME of TREATING DOCTOR for THIS INJURY:	25. DATE LOST TIME BEGAN:
12. DATE of INJURY	13. TIME BEGAN WORK: ____:____ (•) AM ( ) PM	14. TIME of INJURY: ____:____ (•) AM ( ) PM	26. LIST WITNESSESS: (first and last name of each)	
EMPLOYEE'S Signature:				DATE:

****Risk Management Use Only*****

DOH:	Job:	Hrly: $ Daily: $	Amt Last Paid: $
	Contracted Days:	Number of Hours:	Stipend: