

Bay City Public Schools
910 N. Walnut St.
Bay City, MI 48706
(517) 686-9700

EMPLOYEE'S REPORT OF INJURY

Full name of injured employee _____

Address _____ Home Phone No. _____

Sex _____ Age _____ Married or Single _____ Department _____ Badge No. _____

If you have dependent children under 21 years of age living with you complete the following:

Name of Dependent Child	Age	Name of Dependent Child	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Which of above dependent children were not at least 50% supported by you?

Employer's name _____

Occupation when injured _____ Name of Foreman _____

Were you doing your regular work? _____ If not, what work _____

Exact place where injury occurred _____

Date of injury _____ Hour of Day _____ A.M.
P.M.

Witnesses' Names _____

Describe fully how injury happened _____

(Continue on Back if necessary)

What part of your head, limbs or body was hurt? _____

Describe your symptoms: _____

Attending Physician's name and address _____

Number of treatments to date _____

Names and addresses of any other doctors seen _____

Are you still receiving medical treatment? _____ From whom? _____

Did you lose time from work? _____ If so, what was your last day worked? _____

If you have returned to work, what was the date? _____

If you have not yet returned to work, when do you expect to return? _____

To whom was injury reported _____ On what date: _____ Time: A.M.
P.M.

Please sign your name: _____ Date signed _____

If medical attention is necessary your employer will furnish treatment subject to the provision of the Workman's Compensation Act.