Forsyth County Employee Injury/Illness Report

Check one:
☐ I do not wish to file a workers' compensation claim. This 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 their 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 email the report to: everhatg@forsyth.cc or cassidba@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.

Incident Report

Date of Report:	Date of Injury/Illness:	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:	
Date Employer Notified	Date Returned to Work After Injury:	Time Returned to Work After Injury: ☐AM ☐PM	
This is a report of: ☐ Incident Report Only ☐ First Aid Only ☐ Medical treatment ☐ Lost Time ☐ Near Miss			

Incident Occurrence

This incident occurred during what part of your workday?
☐ Entering or Leaving Work ☐ Performing Normal Activities ☐ During Meal Period ☐ During Break

Did it occur on county property? ☐ Yes ☐ No	Name of the location where the incident occurred:	Street Address: City: Zip:

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				

Employment Information

Department Name:		Division Name:	Dept. Address:
Work Phone:	Work Cell:	Employee's Work Email:	
Date Hired:	Job Title:		Months Doing Present Job:
# of Days Worked per Week:	# of Hours Worked per Day:	# of Hours Worked per Week:	
Supervisor's Name:	Supervisor's Phone:	Supervisor's Cell:	

Medical Care / Treatment

☐ I Decline medical treatment
☐ Minor treatment/first aid by employer
☐ Minor medical treatment at UrgentCare, 2311 Lewisville-Clemmons Rd, Clemmons 27012
☐ Baptist Hospital Emergency Department ☐ Hospitalized > 24 hours ☐ Other

Date Treatment Received:	Time: ☐AM ☐PM	Medical Facility Name ***if other than UrgentCare or Baptist Hospital:***
Address ***if other than UrgentCare or Baptist Hospital:***		Phone:
Name of Treating Physician:		Transported to medical facility by:

State specifically what you were doing just before the incident occurred:

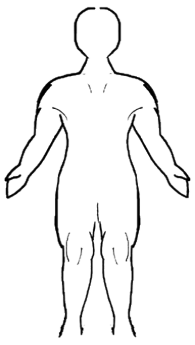
Describe fully how the injury occurred and what you were doing when injured. Be specific about the cause.

State what object or substance directly harmed you. Ex: "concrete floor"; "cleaner fluid", "radial arm saw"; "loaded syringe", etc:. *If this question does not apply to the incident, leave it blank*.

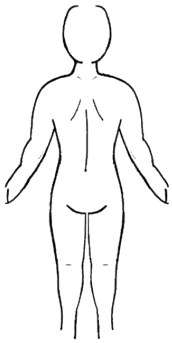
Describe the specific injury and exactly what body part was injured. Ex "left shoulder", "right index finger", "left ankle", etc:

Nature of the Injury/Illness

Part of the body affected (shade in all that apply):



Front



Back

Nature of Injury (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
☐ Damage to a body system Describe:
☐ Dermatitis/Rash
☐ Exposure (bodily fluid, bio hazard)
☐ Hernia
☐ Illness
☐ Insect bite
☐ Sprain, strain
☐ Other: Describe:

Employee's Signature: _____ **Date:** _____

Supervisor's Signature: _____ **Date:** _____

Supervisor's signature acknowledges receipt of this report only and is not a verification of the statements made