# STATE BOARD OF EDUCATION
# LOCAL EDUCATION AGENCY
# INJURY REPORT*
## Alabaster City Schools

| | | | |
|---|---|---|---|
| 1. Name of Injured Employee (Please type or print)<br>(Last) (First) (MI) | 2. Social Security Number<br>_____/_____/_____ | 3. Date of Birth<br>_____/_____/_____ | 4. Sex<br>____ _____<br>Male Female |
| 5. Home Address<br>(Number & Street) (City or Town) (State) (Zip) | 6. Telephone Number<br>Home ( )<br>Work ( ) | 7. Job Title | 8. Status<br>__Full time<br>__Part time<br>__Contract |
| 9. Employing Agency | 10. Agency Address<br>(Number & Street) (City or Town) (State) (Zip) | | |
| 11. Date of Injury | 12. Time of Injury<br>_____ a.m. or p.m. | 13. Date Employer Notified | |
| 14. Is employee covered by medical insurance? __Yes __No<br>If yes: ___Blue Cross/Blue Shield<br>___Other _____ | | 15. Name & Address of Physician | |
| 16. Name & Address of medical facility where treated:<br>___Hospitalized ___Outpatient ___Emergency Treatment | | 17. City or town where injury occurred | 18. Location or place where injury occurred |
| 19. Describe fully what happened to cause the injury or illness | | | |
| 20. Describe the injury or illness in detail and indicate the body part (s) affected | | | |
| 21. Were there any witnesses to the injury? __Yes __No (If "yes", give name, address and telephone number) | | | |
| 22.<br>_____<br>Signature of injured person Print Name Daytime Telephone Number Date | | | |
| 23.<br>_____<br>Signature of Supervisor (or other designated authority) Print Name Daytime Telephone Number Date | | | |



* The employee shall make proper notification of the injury to the executive officer or to the principal of the school within 24 hours after the injury occurred.

# STATE BOARD OF EDUCATION
# LOCAL EDUCATION AGENCY
# PHYSICIAN CERTIFICATION FORM
## Alabaster City Schools

| 1. Name of Injured Employee (Please type or print)<br>(Last) (First) (MI) | 2. Social Security Number<br><br>_____/_____/_____ | 3. Date of Birth<br><br>_____/_____/_____ | 4. Sex<br><br>____ _____<br>Male Female |
|---|---|---|---|
| 5. Home Address<br>(Number & Street) (City or Town) (State) (Zip) | 6. Telephone Number<br>Home ( )<br><br>Work ( ) | 7. Job Title | 8. Status<br><br>__Full time<br>__Part time<br>__Contract |
| 9. Employing Agency | 10. Agency Address<br>(Number & Street) (City or Town) (State) (Zip) | | |
| 11. Date of Injury | 12. Is there reasonable expectation that the employee will be able to return to work?<br><br>____ Yes ____ No | 13. If "yes" on item 12, give the date or approximate date of return.<br><br>_____/_____/_____ | |
| 14. If the employee can return to work, are there any restrictions on the employee's duties? If so, how long will the restrictions apply? | | | |
| 15. If "no" on item 12, give details for employee not being able to return to work. | | | |
| 16.<br><br>_____<br>Signature of Attending Physician Print Name Daytime Telephone Number Date | | | |