

Was the injured employee treated by a physician? Yes () No ()

Date of initial treatment _____

a. Name and address of physician _____

b. Name and address of treating facility (e.g. emergency room, hospital, clinic, etc) _____

Did the employee leave work for longer than the initial medical treatment? Yes () No ()

If so, give date returned to work _____ number of days off work _____

Did the employee die? Yes () No () If so, give date of death _____

If medical attention is not required at time of injury but is later needed, contact the Division of Human Resources immediately once medical attention is received.

Will follow-up medical care be needed? Yes () No () Unknown ()

Date

Signature of injured person (if available)

TO BE COMPLETED BY DEPARTMENT HEAD OR DIRECTOR

Date

Signature of Department Head/Director