

ACCIDENT INFORMATION

EMPLOYEE'S REPORT OF INJURY

ATTENTION EMPLOYEE: SDCL 62-4-51 provides that any person who knowingly files a fraudulent claim for worker's compensation benefits is guilty of a Class 1 misdemeanor.

1. NAME OF SCHOOL DISTRICT:	
2. NAME :	LAST FIRST M.I.
3. WHAT HAPPENED? (If a diagram drawing helps, draw on the back of the form)	
4. NAMES OF WITNESSES: (Persons present at the time of injury)	
5. LOCATION OF ACCIDENT:	
6. HOW WERE YOU HURT?	
7. WHAT IS YOUR INJURY?	
8. DATE OF INJURY:	9. TIME OF INJURY: _____ AM _____ PM
10. DID YOU SEEK MEDICAL ATTENTION? YES _____ NO _____	
11. PHYSICIAN'S NAME, ADDRESS, AND TELEPHONE:	12. HOSPITAL OR CLINIC NAME, ADDRESS, AND TELEPHONE:
13. WHO ACCOMPANIED YOU TO THE HOSPITAL OR CLINIC? NAME: _____ A SCHOOL DISTRICT EMPLOYEE? YES _____ NO _____	
14. DATE REPORT RECEIVED AND NAME OF PERSON RECEIVING REPORT:	

(When this form is sent to the ASBSD, it must be accompanied by the Employer's First Report of Injury)