



MAINE SCHOOL MANAGEMENT ASSOCIATION

49 Community Drive, Augusta, Maine 04330-9405

in the State of Maine 1-800-660-8484

Telephone: (207) 622-3473 Fax: (207) 620-7090

EMPLOYEE'S INCIDENT REPORT

- **REMINDER:** *If your employer has a primary care physician, initial treatment must be through their office. In case of an emergency, proceed to the nearest medical facility.*

This report is requested even though you may have reported this injury to your Supervisor.

Name _____

Address _____ Phone _____

SS# _____ Gender _____ Date of Birth _____ Date of Hire _____ #Dependents _____

Employee Email Address _____ Secondary Email _____

Employer/School _____ Supervisor _____

Do you work for another employer? Name/address of that Employer _____

Occupation when injured _____ Secondary Employment _____

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

Date of injury _____ Hour of day _____ AM ____ PM **What time did you begin work:** _____

Exact place where injury occurred _____

Describe fully how injury occurred: _____

Describe your injury in detail (mention body parts affected) (**specify (L) or (R) side**) _____

Do you have any pre-existing or contributory Injuries/Conditions? _____

Names of any witnesses _____

Name of doctor treating you **for this injury** _____ First Date seen: _____

Doctor's Address _____

Name and addresses of medical providers seen **for this injury** _____

Did you lose time from work? _____ If so, when did disability start? _____

Have you returned to work? _____ When? _____

Light Duty _____ Regular Duty _____ Number of Hours _____ Rate of Pay \$ _____

To whom was injury reported? _____ When (date)? _____ AM ____ PM _____

Date

Signature

“ORIGINAL”

Please copy this form onto PINK paper if available.

Thank You