

FIRST REPORT OF INJURY

Date of report:	Date notified employer:
Date of injury:	Time of injury: ☐ AM ☐ PM

EDUSTAFF EMPLOYEE INFORMATION

Employee name (First Middle Last):		
SSN:	DOB:	Sex: ☐ M ☐ F
Address (number and street):		
City:	State:	ZIP code:
Phone number:	Email:	Hire date:

Job type:					
☐ Administrative	☐ Childcare	☐ Early Childhood	☐ Non-Athletic Coach	☐ Parapro/ Sub Para	☐ Teacher/ Sub Teacher
☐ Aquatics	☐ Coach	☐ Food Service	☐ Non-Classroom Aide	☐ Security	☐ Technology
☐ Athletics	☐ Custodial	☐ Interventionist	☐ Other Support Staff	☐ Special Education	☐ Transportation
☐ Other (if other, please write in correct job type):					
Pay frequency: ☐ Weekly ☐ Biweekly ☐ Semi-monthly ☐ Bulk seasonal					
☐ Other (if other, please write in correct pay frequency):					

INJURY REPORT INFORMATION

Job location:	District:
Injury location (if not the same as job location):	
Address (number and street):	
City:	State: ZIP code:
Assignment start time: ☐ AM ☐ PM	Assignment end time: ☐ AM ☐ PM
Witness(es) to injury:	Witness phone number(s):
Explain how the injury occurred:	
Part(s) of the body injured:	
Last day worked:	Is there likely to be missed work time? ☐ Yes ☐ No ☐ Unknown
Was the injury fatal? ☐ Yes ☐ No	If yes, date of fatality:

MEDICAL TREATMENT

THIS MUST BE COMPLETED BEFORE SUBMITTING.		
Did or will the employee seek medical treatment? ☐ Yes ☐ No ☐ Is going to be seen ☐ Evaluated by school nurse only		
Name of medical facility:		Date of treatment:
Address (number and street):		
City:	State:	ZIP code:
Phone number:	Fax number:	
Other information:		

DISTRICT INFORMATION

THIS MUST BE COMPLETED BY A DISTRICT EMPLOYEE BEFORE SUBMITTING.		
District employee/ supervisor- printed name:		
District employee/ supervisor- <u>SIGNATURE</u> :		
Title:		Date:
Phone number:	Email:	
Additional feedback:		

Please return **both completed pages** via a single PDF attached to an email to Edustaff Human Resources at humanresources@edustaff.org. Thank you!

EMAIL FORM

By clicking the EMAIL FORM button, a new email will open to HumanResources@edustaff.org with the form included as a PDF attachment.

RESET FORM

AUTHORIZATION FOR TREATMENT - Workers' Compensation

This form authorizes a health care provider to treat the following Edustaff employee.

Employee → bring this form with you when you seek medical treatment.

Employee name:

Date of injury:

Location where injury happened:

Send all billing information to:

AmTrust Financial Services, Inc.
PO Box 89404
Cleveland, OH 44101
Policy #: MWC1040642

Bills may also be faxed to 678-258-8395.

If you have any questions, please contact Edustaff Human Resources at 877-974-6338 or HumanResources@Edustaff.org.