MAINE SCHOOL MANAGEMENT ASSOCIATION
INSURANCE PROGRAMS
49 Community Drive, Augusta, ME 04330
Telephone: (207) 626-5450 W/C Fax: (207) 620-7090
Website: *www.msmaweb.com*

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 _____ Cell Phone _____

Address _____ Home 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?** _____

What time did you leave work: _____

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