



DETROIT PUBLIC SCHOOLS REPORT OF INJURY/EMPLOYEE

PLEASE TYPE OR PRINT ONLY:

This form must be **completed entirely**, including the Authorization of Medical Treatment and Authorization for Medical Reports and Records, within **24 hours** of the injury. Forward original copy to the Office of Risk Management, 3011 W. Grand Blvd., Suite 1101, Detroit, MI 48202 via facsimile copy to 313-873-0879.

DPS Employee ID _____ DATE OF REPORT (mm/dd/yy) _____

1. INJURED EMPLOYEE _____ LAST 4-DIGITS OF S.S. NO. _____
 ADDRESS _____ CITY _____ ZIP CODE _____ PHONE NO. _____

2. BIRTHDATE: (mm/dd/yy) _____ SEX _____

3. NUMBER OF DEPENDENTS UNDER AGE 16 ____ FILING STATUS AT TIME OF INJURY _____

4. DATE OF INJURY:(mm/dd/yy) _____ TIME _____ LAST DAY WORKED : (mm/dd/yy) _____

5. WHERE? ADDRESS _____ CITY _____ STATE _____

6. WAS PLACE OF ACCIDENT OR EXPOSURE ON EMPLOYER'S PREMISES? YES NO

7. NAME AND ADDRESS OF ATTENDING PHYSICIAN/HOSPITAL _____

8. ANALYSIS CATEGORY	DESCRIPTION
A. NATURE OF INJURY (Burn, Cut, Amputation, Sprain?)	
B. PART OF BODY (Eye, Arm, Finger, Left Hand, Right Leg?)	
C. HOW DID ALLEGED INJURY OCCUR? (Describe actual events, what and how?)	
D. NAME OF OBJECTS/SUBSTANCE WHICH DIRECTLY INJURED EMPLOYEE (Describe actual object(s)/ substance involved in injury.)	

9. NORMAL WORK SITE _____

10. ADDRESS _____ TELEPHONE _____

11. JOB TITLE _____ NO. OF REG. WORK HRS. _____ REG. HRLY. WAGE _____

12. ACCIDENT REPORTED TO: NAME _____ DATE _____ TIME _____

13. WITNESSES 1) _____ 2) _____
 ADDRESS/ HOME PHONE 1) _____ 2) _____

14. FIRST DAY OF ABSENCE DUE TO INJURY _____ DID EMPLOYEE EXPIRE? YES NO
 DATE OF DEATH _____ 15.) ARE YOU REQUESTING ASSAULT BENEFITS? YES NO

16. DATE RETURNED TO WORK _____ 17. OR, ESTIMATED LOST TIME FROM WORK _____

SIGNATURE OF EMPLOYEE _____ SIGNATURE OF SUPERVISOR _____

AUTHORIZATION FOR MEDICAL TREATMENT

The herein named Detroit Public Schools employee has received authorization for medical treatment as evidenced by the required signature of his/her Supervisor.

DATE AND TIME: _____

NAME OF APPROVED CLINIC OR PHYSICIAN: _____

PLEASE RENDER MEDICAL TREATMENT TO THE FOLLOWING NAMED DETROIT PUBLIC SCHOOLS' EMPLOYEE:
 EMPLOYEE: _____ DEPARTMENT: _____
 DESCRIPTION OF INJURY: _____

SUPERVISOR: _____ TELEPHONE NO.: _____

PRINTED NAME OF SUPERVISOR: _____

AUTHORIZATION FOR MEDICAL REPORTS & RECORDS

TO WHOM IT MAY CONCERN:

You are authorized to give verbally or in writing to any Detroit Public School representative thereof, any and all information which may be requested regarding my physical condition and treatment rendered by you, and if necessary, to allow them, or any physician appointed by them to examine any x-ray pictures taken of me, or records which you may have regarding my condition or treatment. A photostatic copy of this authorization shall serve in its stead. THIS AUTHORIZATION HAS NO EXPIRATION.

SIGNATURE: _____ DATE: _____

PRINTED NAME OF EMPLOYEE: _____

LAST 4-DIGITS OF S.S. NUMBER OR DPS EMPLOYEE ID: _____

WITNESS SIGNATURE: _____ DATE: _____