RESET FORM

PRINT

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 Female

3. NUMBER OF DEPENDENTS UNDER AGE 16 ____ FILING STATUS AT TIME OF INJURY MARRIED/ FILING JOINTLY

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

5. WHERE? ADDRESS _____ CITY Detroit STATE Michigan

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?)	Abdomen Front
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: NO MEDICAL TREATMENT SOUGHT

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: _____