

**Rio Brazos Education Cooperative
Worker's Compensation
First Report of Injury or Illness**

*The form must be COMPLETELY filled out and submitted to
Jeane Gauer before going to a physician or hospital.
Fax: 254-756-7695*

1. Today's Date:
2. Name (Last, First, Middle):
3. Date of Birth:
4. Social Security Number:
5. Address:
6. Home Phone Number:
7. Sex:
8. Marital Status:
9. Occupation/Job Title:
10. Number of Dependents:
11. Time Employee Began Work:
12. Date of Injury:
13. Time of Occurrence:
14. Last Work Date:
15. Date Employer Notified:
16. Type of Injury:
17. Part of Body Affected:
18. Where accident occurred(what school):
19. Equipment or chemicals involved:
20. Work process involved:

21. Describe how injury happened:

22. Date Returned to Work:

23. If Fatal, Give Date of Death:

24. Physician/Health Care Provider (Name & Address):

25. Hospital (Name & Address):

26. Initial treatment: (place a " x " beside the treatment received)

No Medical Treatment
Minor by Employer
Minor Clinic/Hospital
Emergency Care
Hospitalized-24 Hrs
Future Major Medical/Lost Time Anticipated

27. Witnesses (Name & Phone Numbers):