Birmingham City Schools

Local Education Agency Employee Injury Report Form

1. Injured Employee's Name	2. Social Security Number	3. Date of Birth	4. Sex
5. Home Address	6. Telephone Number	7. Job Title	8. Status ___ Full Time___ Substitute ___ Part Time
9. School/Worksite Location	10. Employer's Name	11. Employer's Address	
12. Date of Injury	13. Time of Injury ____:_____ ___AM ___PM	14. Date Employer Notified of Injury	
15. Is employee covered by medical insurance? ___ Yes ___ No If yes, which medical insurance plan: ___ Blue Cross/Blue Shield ___ Other: _____	16. Name and address of attending physician		
17. Name and address of medical facility where treated ___Hospitalized ___ Outpatient ___Emergency	18. Location or place where injury occurred City: _____ State: _____ School/Building: _____		
19. Describe fully what happened to cause the injury or illness.			
20. Describe the injury or illness in detail and indicate the body part(s) affected.			
21. Were there any witnesses to the injury? ___ Yes ___ No (If "yes" give name, address, and telephone number)			

22. Signature: I certify that the statements in response to the questions asked above are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statements or any misrepresentation or concealment of material fact, which is knowingly made, may subject me to felony criminal prosecution.

Signature of Injured Employee _____ Telephone Number _____

Print Name of Injured Employee _____ Date _____

23. Received By:

Signature of Employer/Supervisor _____ Telephone Number _____

Print Name of Employer/Supervisor _____ Date _____

Birmingham City Schools

Local Education Agency Physician Certification Form

1. Patient's Name	2. Social Security Number	3. Date of Birth	4. Sex
5. Home Address	6. Telephone Number	7. Job Title	8. Status ___ Full Time___ Substitute ___ Part Time
9. School/Worksite Location	10. Employer's Address		11. Date of Injury

12. What history of injury (including disease) did patient give you?

13. Is there any history or evidence of concurrent or pre-existing injury or disease physical impairment? If yes, please describe.

14. What are your findings?

15. What is your diagnosis?

16. Do you believe the condition found was caused or aggravated by an employment activity? If yes, please explain.

17. Did injury require hospitalization?	18. Date of admission	19. Date of discharge
20. What treatment did you provide?		
21. Date of first examination	22. Date(s) of treatment: (M/D/Y)	23. Date of discharge from treatment
24. Period of total disability	25. Period of partial disability	26. Date employee is able to resume work
27. Has employee been advised that he/she can return to work?	28. If yes, on what date was he/she advise?	

29. If you have referred the employee to another physician provide the following:

Name _____

Address _____

City _____ State _____ Zip _____

30. Specialty

31. Reason for Referral
___ Consultation
___ Treatment

32. Signature: I certify that the statements in response to the questions asked above are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statements or any misrepresentation or concealment of material fact, which is knowingly made, may subject me to felony criminal prosecution.

Signature of Attending Physician _____ Telephone Number _____

Print Name of Attending Physician _____ Date _____