## **ACCIDENT INFORMATION**

## **EMPLOYEE'S REPORT OF INJURY**

**ATTENTION EMPLOYEE: SDCL 62-4-51** provides that any person who knowingly files a fraudulent claim for workers' compensation benefits is guilty of a Class 1 misdemeanor.

## Please call 877.337.2156 PRIOR to seeking any medical treatment

1. NAME C	OF SCHOOL DISTRICT:				
2. NAME:	LAST	FIRST	M.I.		
3. WHAT H	IAPPENED? (If a diagram drawing help	s, draw on the back of the form)			
4. NAMES	OF WITNESSES: (Persons present at t	he time of injury)			
	or verrezoszor (reisons present acc	ne time of injury)			
5. LOCATIO	ON OF ACCIDENT:				
6. HOW W	ERE YOU HURT?				
7 14/110716	C VOLID INILIDY2				
7. WHAT IS	S YOUR INJURY?				
8. DATE O	F INJURY:	9. TIME OF INJURY: _	A.M	P.M.	
10. DID YO	OU SEEK MEDICAL ATTENTION?	YES	NO		
11. PHYSIC	CIAN'S NAME, ADDRESSS, AND TE	LEPHONE: 12. HOSPIT	AL OR CLINIC NAME, ADDR	ESS AND TELEPHONE:	
12 14110 4	ACCOMPANIED VOLLTO THE HOSE	NTAL OR CUNICS			
	ACCOMPANIED YOU TO THE HOSI	TIAL OR CLINIC?			
NAME:					
A SCHOOL	DISTRICT EMPLOYEE? YES	NO			
110011002			<del></del>		
14. DATE R	REPORT RECEIVED AND NAME OF	PERSON RECEIVING REPORT:			
(When this	form is sent to the ASBSD, it must be	accompanied by the Employer's	First Report of Injury)		