



De Smet School District 38-2
 Business Office
 PO Box 157 De Smet, SD 57231
 (P) 605-854-3674
 DeSmet.k12.sd.us

EMPLOYEE REPORT OF INJURY

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

First Name: _____ M.I.: _____ Last Name: _____

What happened? (If a diagram drawing helps, draw on the back of the form): _____

Names of Witnesses (persons present at the time of injury): _____

Location of Accident: _____

How were you hurt? _____

What is your injury? _____

Date of Accident: _____ Time of Accident: _____

Did you seek medical attention? Yes _____ No _____

	Physician Information	Hospital/Clinic Information
Name		
Address		
Telephone		

Who accompanied you to the hospital or clinic? _____

A school district employee? Yes _____ No _____

Signatures

Employee's Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

Administrator Signature: _____ Date: _____

*****ORIGINAL FORM MUST BE FILED IN THE BUSINESS OFFICE*****
 BUSINESS OFFICE MUST SUBMIT THIS FORM WITH THE EMPLOYER'S FIRST REPORT OF INJURY