TO PERMIT PROMPT ATTENTION TO THIS MATTER, PLEASE COMPLETE THIS FORM AND RETURN IT WITHIN 24 HOURS TO:

HUMAN RESOURCES OFFICE
SMCC – FORT BUILDING
PH: (207) 741-5568 FAX (207) 741-5582

EMPLOYEE'S REPORT OF INJURY

Soc. Sec. No: _____-_____-_____

Full name of injured employee _____

Address _____ Phone # (____) ____-_____

Date of Birth ___/___/_____ Occupation when injured _____

Date of hire _____ Name of Supervisor_____

Were you doing your regular work? **Yes / No** If not, what type of work? _____

Do you work for another employer? **Yes / No**

If yes, give name and address: _____

Exact place where injury occurred _____

Date of injury ___/___/_____ Time ____:_____ am/pm Your regular start time ____:_____am/pm

To whom was the injury reported? _____ Date ____/____/_____

Witnesses' Names _____

Describe fully how injury happened _____

_____

Describe your injury in detail _____

_____

Have you ever had this type of injury before? If so, please explain. _____

_____

Was safety equipment provided: **Yes** / **No** Used: **Yes** / **No** Explain: _____

Did you lose time from work? **Yes** / **No** If so, when did disability begin? ___/___/_____

If you have returned to work, what was the date? ___/___/_____

Are you declining medical treatment at this time? _____

IF MEDICAL ATTENTION IS NECESSARY AND THE INJURY/ILLNESS IS NOT LIFE THREATENING, EMPLOYEES ARE REQUIRED TO USE SMCC'S PROVIDER, BAYSIDE EMPLOYEE HEALTH CENTER OR US HEALTHWORKS (MIDCOAST) FOR THE FIRST 10 DAYS OF TREATMENT. INITIAL EVALUATION/APPOINTMENT NEEDS TO BE SCHEDULED BY THE HR OFFICE. PLEASE CONTACT THE HR MANAGER AT (207) 741-5568 IF AN APPOINTMENT IS NEEDED OR IF YOU HAVE ANY QUESTIONS.

HEALTH CARE PROVIDER: Bayside Employee Health Center

ADDRESS: 50 Sewall Street, Suite 301, Portland, ME 04102

PHONE: 207-780-6631

EMPLOYEE SIGNATURE _____ **DATE** ____/____/_____