Workers' Compensation Report Only Form

Alliance of Schools for Cooperative Insurance Programs

16550 Bloomfield Avenue • Cerritos, CA 90703 • PH: (562) 404-8029 FAX: (562) 404-8038 • www.ascip.org

CONFIDENTIAL – ATTORNEY/CLIENT WORK PRODUCT PRIVILEGE

This report is to be completed by agency employees. This form is a confidential, internal, document: its contents are not to be shared or copied for any persons who are not agency employees and/or their legal representatives.

DATE OF REPORT

NOTE: Please type or print using ball-point pen.

In the event an employee chooses to only report an injury or illness and does not currently wish to pursue a claim, this form should be completed.

1 NAME OF AGENCY		2 NAME OF SCHOOL	
ADDRESS OF AGENCY (NUMBER, STREET, CITY AND ZIP CODE)			
3 NAME OF INJURED PERSON (LAST, FIRST, M.I.)	AGE / DOB		TELEPHONE NUMBER OF INJURED PERSON ( )
4 ADDRESS OF PERSON INJURED (NUMBER, STREET, APARTMENT NUMBER, CITY, STATE AND ZIP CODE)			
5 ADDRESS WHERE THE ACCIDENT OCCURRED		DATE (MONTH/DAY/YEAR)	TIME ☐ A.M. ☐ P.M.
SPECIFIC LOCATION OF THE INCIDENT (CAFETERIA, WAREHOUSE)			
6 DESCRIBE HOW ACCIDENT OCCURRED (USE FACTS ONLY; EXCLUDE OPINIONS AND/OR ASSUMPTIONS)			
7 SIGNATURE OF THE INJURED PERSON		DATE (MONTH/DAY/YEAR)	TIME ☐ A.M. ☐ P.M.

8 NAME OF WITNESS(ES)	ADDRESS	TELEPHONE NO.	STATUS (F/T, P/T, Sub, etc.)
		( )	
		( )	

9 APPARENT NATURE OF INJURY (PLEASE CHECK)

☐ Abrasion ☐ Fracture ☐ Strain/Sprain
☐ Contusion ☐ Cut ☐ Dislocation
☐ Internal ☐ Concussion
☐ Other (explain) _____

10 INJURED PART OF BODY (PLEASE CHECK)

☐ Right (and/or) ☐ Left

☐ Head ☐ Finger ☐ Arm ☐ Abdomen
☐ Neck ☐ Eye ☐ Leg ☐ Hand
☐ Back ☐ Chest ☐ Face ☐ Foot
☐ Other (explain) _____

11 FIRST AID PROCEDURES USED	NAME OF PERSON WHO ADMINISTERED FIRST AID

12 REMARKS

13 NAME OF PERSON COMPLETING REPORT	JOB TITLE	TELEPHONE NUMBER OF PERSON ( )
ADDRESS OF PERSON (NUMBER, STREET, CITY, STATE AND ZIP CODE)		DISTRICT SITE
SIGNATURE OF PERSON COMPLETING REPORT		DATE SIGNED