RED CLAY CONSOLIDATED SCHOOL DISTRICT
PRELIMINARY REPORT FOR WORKERS' COMPENSATION CLAIM

NOTE: ***ALL INFORMATION MUST BE COMPLETED.*** **This form must be submitted to Ms. Renee Velazquez, Red Clay Consolidated School District, Workers Compensation Office, 1502 Spruce Avenue, Wilmington, DE 19805, within five calendar days of the injury. If not, the Industrial Accident Board imposes a fine for late reporting. This amount will be charged against the budget of the school/department.**

***IF *ALL* INFORMATION IS NOT FILLED IN & THE WORKERS' COMPENSATION OFFICE CAN'T OBTAIN THE MISSING INFORMATION FROM THE SCHOOL/DEPARTMENT IN TIME TO MEET THE DEADLINE, ANY FINE IMPOSTED WILL BE CHARGED AGAINST THE BUDGET OF THE SCHOOL/DEPARTMENT.**

**PLEASE PRINT LEGIBLY

1. INJURED EMPLOYEE'S NAME: _____

2. INJURY DATE: _____ INJURY TIME: _____

3. PLACE OF INJURY:_____
If not on Board property, list the exact address including street number & name, city, state and zip.

4. Date employee REPORTED injury: _____

5. NORMAL STARTING TIME FOR EMPLOYEE: _____

6. DATE OF RETURN TO WORK: _____ (*indicate if still out or if no time was lost*)

7. Date *employer* was informed of the accident/injury: _____

8. Was injury/illness witnessed? Yes _____ No _____ If answer is YES, provide CONTACT NUMBER & NAME of witness.
_____

9. What was the employee doing when injured? *BE SPECIFIC*
_____
_____
_____

10. Was she/he using tools? _____ If yes, what tools?
_____

11. Was she/he using the equipment properly or as instructed? Yes _____ No _____ (If no, explain._____
_____

12. How did the injury occur? *<u>BE SPECIFIC</u>* If necessary, type the response on a separate page and attach to this form.
_____
_____
_____
_____

13. Do you or the principal/supervisor believe the injury was caused by a mechanical defect? YES_____ NO_____ (YOU MUST ANSWER YES OR NO). If yes, save the piece of equipment until you are contacted by someone from PMA Management Corporation. In the interim do not allow anyone to touch it or use it. ***If you are not the principal/supervisor, be sure you inform the person in charge of the above requirement.***

14. Does anyone think the injury was caused by an unsafe act? YES_____ NO_____ You must answer either YES or NO. If your answer is yes, list the names and locations of witnesses or the person who thinks there was an unsafe act.
_____
_____
_____
_____
_____

15. Did any amputation result from the injury/accident? YES_____ NO_____

16. What part of the body was injured? *BE SPECIFIC* _____
If extremities, list either right or left.

17. What was the nature of the injury? Cut, burn, sprain, etc. _____

18. Name and address of the attending physician, emergency room or hospital.

PHYSICIAN:_____
ADDRESS:_____
_____

TELEPHONE: _____

EMPLOYEE SIGNATURE:_____ DATE:_____

NAME AND TITLE OF PERSON SUBMITTING THIS FORM:
_____

WORK
LOCATION: _____ PHONE:_____

DATE REPORT IS SUBMITTED: _____

First aid notes:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

PLEASE EMAIL FORM TO: WORKERSCOMPENSATION@REDCLAY.K12.DE.US

FAX TO: 302-992-7821, ATTN: RENEE VELAZQUEZ

INTEROFFICE MAIL: ATTN: RENEE VELAZQUEZ
DISTRICT OFFICE, RM 135
1502 SPRUCE AVENUE
WILMINGTON, DE 19805

IF YOU HAVE ANY QUESTIONS, PLEASE EMAIL:
WORKERSCOMPENSATION@REDCLAY.K12.DE.US OR CALL RENEE VELAZQUEZ @ 302.552.3738