

**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, and the Workers' Compensation office can't obtain the missing information from the school/department in time to meet the deadline, any fine imposed 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 knew of the injury: _____

5. Normal starting time for this 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 name and contact number of witness.

9. What was the employee doing when injured?

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? Be specific. 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:

FAX THIS REPORT TO : Renee Velazquez 302-992-7821

SEND ORIGINAL TO: Renee Velazquez
Red Clay Consolidated School District
Workers' Compensation Office
1502 Spruce Avenue, Room 135
Wilmington, DE 19805

You can also email your completed form to: Workerscompensation@Redclay.K12.De.Us

**IF YOU HAVE ANY QUESTIONS, PLEASE CALL MICHELE HARTNETT @ 302-552-3812
OR RENEE VELAZQUEZ @ 302-552-3738.**

