FCSU - EMPLOYEES FIRST REPORT OF INJURY

Complete thoroughly - Forward to Central Office Immediately, Attn: Benefits Coordinator
FCSU FAX: 802.524.1540, gcross@fcsuvt.org
(If getting the form is held up, email or call with as much information as you have and follow up with the form)

Reporting Location:

Bellows Free Academy UHS / NWTC		St. Albans City School		Central Office	
Collins Perley Sports & Fitness		St. Albans Town Educational Ctr		Fairfield Center School	

Employee Personal Information:

Name (Last, First, MI)	Home Phone:	Soc. Sec. Number __ __	
Street Address:	Gender Female ☐	Date of Birth / /	Date of Hire / /
City, State, Zip:	Male ☐	Job Title:	

Accident & Injury Details:

Date & Time _____ / _____ / _____ of Accident: _____ : _____ AM PM	When did employees shift start: _____ : _____ AM PM Exactly where was employee: (ie: entryway in front of building)
Describe in detail the injury and the part of the body injured: (be sure to include L or R)	

Medical:

Our employees are to go to: Northwest Occupational Health Cobblestone Health Commons 260 Crest Road, Suite 101 St. Albans, VT 05478 (p) 524-1223 (f) 524-1095	Has employee sought treatment ☐ Yes ☐ No - If this changes, notify me immediately At NOH? ☐ Yes ☐ No If not NOH, where: Witnesses:
Has employee lost any time from work? _____	If yes, date disability began: _____ / _____ / _____
Has employee returned to work? _____	If yes, date returned: _____ / _____ / _____

Signatures:

Employee: _____ Date: _____

Employer Representative on site:_____ Date: _____

Central Office:

Reported on: _____ Claim # _____ Adjuster: _____