City of St. Augustine

Injury and Illness Report

Please complete all information

Name: _____ Date of Injury: _____

Phone: _____ Date of Birth: _____ Time of Injury: _____

Home Address: _____

Location/Address where injury/illness occurred: _____

Witnesses: _____

Specific Body Part Injured: _____
(left, right, lower, upper, etc.)

Any prior injuries to this body part? If yes, please explain

Describe Injury (pain, cut, bruise, swelling, etc.)

Describe the incident (please explain what you were doing prior to and **what caused the injury**):

Did you request medical treatment? Yes _____ No _____

Did you receive medical treatment? Yes _____ No _____

If yes, from whom: _____

Did you receive the worker's compensation information from your Supervisor? Yes _____ No _____

Please sign and date that the above information is correct and that you understand filing an injury claim containing any false or misleading information is insurance fraud:

_____
Employee Signature

****

Supervisors' Comments, Clarification, Additional Information, Could this have been prevented, Safety Violations:

Date Reported to Supervisor: _____ Time Reported: _____

Supervisor's Signature: _____ Reviewed by: _____

****

Human Resources:

Case #_____ Treated in ER: _____ Date of Hire _____ Rate of Pay: _____

Job: _____ FAMO DA, first day lost: _____

Confirmation #_____

WORKERS' COMPENSATION
EMPLOYEE ACKNOWLEDGEMENT OF DUTIES

I, _____, acknowledge that I am either currently receiving treatment under Workers' Compensation, or if I elect to receive future treatment for the work-related injury sustained on _____, the following applies:

I understand that the restrictions set forth by my physician are valid both inside and outside of the workplace and I must comply with them at all times. _____Initial

I understand that my physician will provide the City with information regarding physical restrictions if I am unable to return to work in full capacity due to the nature of my injury. These limitations are outlined by my physician so that I may return to work as soon as possible while still achieving full recovery from my injury. The City will make every attempt to find me a suitable alternate/modified work assignment which will allow me to return to work in a capacity that meets these restrictions. _____Initial

I understand that I must comply with any light duty assignment provided to me by my employer. I will be paid my regular hourly rate regardless of the limitations my doctor has set on duties performed. I further understand that these job duties are temporary in nature, and I may transition back to my regular job assignment once my doctor has determined I am capable. _____Initial

I acknowledge that if I refuse a light duty assignment, I am limiting my income. I will not be paid Workers' Comp and will use my accrued leave time until I am released to perform my regular work assignment. _____Initial

I agree to keep Human Resources and my supervisor apprised of any changes in my physical restrictions and will advise my employer within 24 hour of changes to my restrictions or my release to full duty by my physician. _____Initial

I understand that all City policies, including attendance, punctuality and call off procedures will apply as usual during this transitional work period. _____Initial

_____ _____

Signature Date