CITY OF KENTON

EMPLOYEE INCIDENT / ACCIDENT REPORT

BACK INJURY REPORT

*** To Be Completed When a Back Injury is Reported by the Injured Employee***

Name: ______________________________ Social Sec. No. XXX-XX-________ (Last 4-digits only)

Home Address: ______________________________ Date of Birth: ________ Sex: ☐ Male ☐ Female

City/State/Zip: ______________________________ Telephone: (   ) ______________________

Title/Position: ______________________________ Department: ______________________

What part of your back hurts now? ______________________________

When did you first notice this back pain? Date: ________________ Time: ________ ☐ am ☐ pm

What were you doing at that time (explain in detail)? ______________________________

____

____

If you were lifting an object, what was it and how heavy? ______________________________

____

____

What did you feel? ______________________________

What was the length of time between the injury and your disability, if any? ______________________

Did anyone see you get hurt? ☐ Yes ☐ NoIf yes, who? ______________________________

Did you report or mention this injury to anyone? ☐ Yes ☐ No If yes, who? ____________ When? ________

Did you ever have a back injury before? ☐ Yes ☐ No If yes, when? ______________________

What part of your back? ______________________________

Were you ever treated by a doctor? ☐ Yes ☐ No If so, when? ______________________

Has it given you further trouble since then? ______________________________

Have you ever received or filed for compensation because of a back injury? ☐ Yes ☐ No

Any other injury? ☐ Yes ☐ No If yes, list Bureau of Workers' Compensation claim number(s): ____________

____

Medical Release **- Under current Workers' Compensation Law, the employer is entitled to a signed medical release.** I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to **disclose such information** to my employer, my employer's managed care organization, or to my employer's designated representative. A copy of this form will serve as the original.

Employee Name (print): ______________________________

Employee Signature: ______________________________ **Date (required):** ________________