Risk Mgmt. Verification Use Only
Date Received / /
Confirmed/File ☐ Yes ☐ No

Claim Entry Verification	
STATE Pay	LOCAL Pay
Claim Number	Claim Number

PITT COUNTY SCHOOLS
WORKERS' COMPENSATION EMPLOYEE STATEMENT

EMPLOYEE INFORMATION

Full Name: _____ Date of Birth: ___/___/___

Soc. Sec. No.: XXX–XXX-_____ Employee No.: _____

Address: _____ City: _____ State: _____ Zip: _____

Home/Cell No: (___) _____ Work Phone No.: (___) _____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Temporary ☐ Substitute

Work Site/Department: _____ Position/Job Title: _____

Email address: _____

Regular Work Hours: _____ Per Day: _____ Per Week: _____

Site Administrator's Name: _____ Title: _____

Immediate Supervisor's Name: _____ Title: _____

Principal/Site Administrator and Supervisor must be immediately notified of all accidents and incidents

INCIDENT/INJURY INFORMATION

Exact Location Incident Occurred: _____

Date of Incident: ___/___/___ Time of Incident: _____ ☐ A.M ☐ P.M.

Time you began work on day of incident: _____ ☐ A.M ☐ P.M.

To whom did you initially report the incident? _____

Date Initially Reported: ___/___/___ Time Initially Reported: _____ ☐ A.M ☐ P.M.

Date ___/___/___ and Time _____ ☐ A.M ☐ P.M Supervisor was notified of incident.

Describe, step-by-step the events that led up to the incident. Include names of any machines, parts, objects, tools, materials and other important details:

_____

_____

Description continued on attached sheets: ☐

What could be done to avoid recurrence? _____

Were you injured as a result of this incident? ☐ Yes ☐ No

Body part(s) injured (be specific): _____ Type of Injury (e.g., laceration, strain, etc.): _____

Have you ever received medical treatment for this condition before? ☐ Yes ☐ No

MEDICAL TREATMENT

☐ None Needed ☐ Refused ☐ First Aid ☐ School Nurse Assessment

☐ *PCS Authorized Workers' Comp Medical Provider ☐ Emergency Treatment Required

Upon receipt of employee's request for medical treatment, the Risk Manager will provide authorization for medical treatment at Pitt County Schools' preferred medical provider. Employee should not seek medical treatment for an on the job injury through their personal provider. If it is determined that the injury is not a compensable claim under the Workers' Compensation Act, **employee may be responsible** for all medical expenses incurred.

WITNESS INFORMATION

Witnesses: ☐ Yes ☐ No ☐ Unknown

Please list Adult witnesses if applicable:

1. _____ 3. _____

2. _____ 4. _____

NOTE

1. Waiting Period – No compensation shall be paid for the first seven calendar days of disability unless the disability continues for more than 21 days. Leave may be used during the first seven days should your doctor require you to remain out of work. If leave exceeds available balance, Leave Without Pay will automatically be charged.

2. Workers' Compensation Rate – The rate is sixty-six and two-thirds (66 2/3 %) of the average weekly wage during the 52 weeks immediately preceding the date of injury not to exceed the maximum established by the N.C. Industrial Commission.

ARTICLE 1. Workers' Compensation Act, Section §97-88.2. Penalty for fraud.

(a) Any person who willfully makes a false statement or representation of a material fact for the purpose of obtaining or denying any benefit or payment
(b) or assisting another to obtain or deny any benefit or payment under this Article
(c) shall be guilty of a Class 1 misdemeanor if the amount at issue is less than one thousand dollars ($1000). Violation of this section is a Class H felony if the amount at issue is one thousand dollars ($1000) or more. The court may order restitution.

SIGNATURE

By my signature, I certify that I understand the contents of this document and acknowledge that all statements provided by me on this form are true and accurate.

Signature: _____ Date: _____

Effective 08/23/2016