INDIANA WORKER'S COMPENSATION
FIRST REPORT OF EMPLOYEE INJURY, ILLNESS

State Form 34401 (R10 / 1-02)

FOR WORKER'S COMPENSATION BOARD USE ONLY		
Jurisdiction	Jurisdiction claim number	Process date

Please return completed form electronically by an approved EDI process.

PLEASE TYPE or PRINT IN INK

NOTE: Your Social Security number is being requested by this state agency in order to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.

EMPLOYEE INFORMATION

Social Security number	Date of birth	Sex	Occupation / Job title	NCCI class code
		☐ Male ☐ Female ☐ Unknown		

Name (*last, first, middle*)	Marital status	Date hired	State of hire	Employee status
	☐ Unmarried ☐ Married ☐ Separated ☐ Unknown			

Address (*number and street, city, state, ZIP code*)	Hrs / Day	Days / Wk	Avg Wg / Wk	☐ Paid Day of Injury ☐ Salary Continued

Telephone number (include area	Number of dependents	Wage	Per
		$	☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year ☐ Other

EMPLOYER INFORMATION

Name of employer	Employer ID#	SIC code	Insured report number
Plymouth Community School Corporation	35-1101903		

Address of employer (*number and street, city, state, ZIP code*)	Location number	Employer's location address (*if different*)
611 Berkley Street Plymouth, IN 46563	Telephone number (574) 936-3115	

Carrier / Administrator claim number	OSHA log number	Report purpose code

Actual location of accident / exposure (*if not on employer's premises*)

CARRIER / CLAIMS ADMINISTRATOR INFORMATION

Name of claims administrator	Carrier federal ID number	Check if appropriate
The Zenith		☐ Self Insurance

Address of claims administrator (*number and street, city, state, ZIP code*)	☑ Insurance Carrier ☐ Third Party Admin.	Policy / Self-insured number
PO Box 1558, Sarasota, FL 34230-1558		Z139760001

Telephone number	Policy period
(800) 440-5020	From 01/01/2023 To 01/01/2024

Name of agent	Code number
Gibson Insurance Agency	

OCCURRENCE / TREATMENT INFORMATION

Date of Inj./ Exp.	Time of occurrence ☐ AM ☐ PM ☐ Cannot be determined	Date employer notified	Type of injury / exposure	Type code

Last work date	Time workday began	Date disability began	Part of body	Part code

RTW date	Date of death	Injury / Exposure occurred on employer's premises? ☐ Yes ☐ No	Name of contact	Telephone number

Department or location where accident / exposure occurred	All equipment, materials, or chemicals involved in accident

Specific activity engaged in during accident / exposure	Work process employee engaged in during accident / exposure

How injury / exposure occurred. Describe the sequence of events and include any relevant objects or substances.

Cause of injury code

Name of physician / health care provider

Hospital or offsite treatment (*name and address*)

INITIAL TREATMENT
- ☐ No Medical Treatment
- ☐ Minor: By Employer
- ☐ Minor: Clinic / Hospital
- ☐ Emergency Care
- ☐ Hospitalized > 24 Hours
- ☐ Future Major Medical / Lost Time Anticipated

Name of witness	Telephone number	Date administrator notified

Date prepared	Name of preparer	Title	Telephone number

An employer's failure to report an occupational injury or illness may result in a $50 fine (IC 22-3-4-13).

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EMPLOYEE REPORT OF INJURY
(To be completed by the employee only)

The purpose of this report is to help with the claims reporting process. It should be completed and signed by the injured worker.

Date of Injury: _____ Time of Injury: _____ AM/PM

Name: _____ Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Job Title/Occupation: _____ Months on this job: _____

Social Security No: _____ Weekly Salary: _____

Supervisor: _____ Phone: _____

When did you report the accident and to who? _____

Do you require medical attention? Yes: _____ No: _____ Maybe: _____

Location of accident (entrance, loading dock, bathroom, etc.): _____

_____

_____

Name of Witness(es): _____

Please describe in detail how the incident occurred and what you were doing when the incident occurred? _____

_____

_____

_____

What did you hurt? What body parts were affected? _____

_____

_____

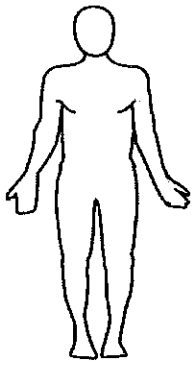
_____

What is at least one thing we can do to prevent this accident from happening again? _____

_____

_____

Employee Signature: _____ Date: _____



Circle the body parts

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SUPERVISOR INCIDENT INVESTIGATION REPORT

The purpose of this report is to help prevent similar incidents from recurring. Make this report as accurate and thorough as possible. Remember, always follow-up with the appropriate corrective actions.

Investigation Conducted by: _____ Date: _____

Incident Type: ☐ Near Miss ☐ Injury ☐ Illness

Incident Date: _____ Time: _____ AM/PM

Injured Worker: _____ Department: _____

Occupation: _____ Months on this job: _____

Describe the injury or damage, be specific: _____

_____

_____

_____

Who was nearby? (list names) _____

_____

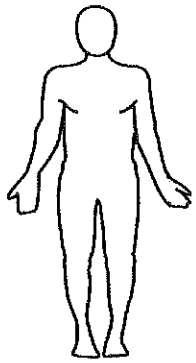
_____

_____

Where did the incident occur? _____

_____

_____



Circle the body parts

What was the employee doing at the time of injury?

☐ Regular Job Task ☐ Specially Assigned Task ☐ Unassigned Task

Describe the task. How many days/months/years has the employee been performing this task:

_____

☐ On Break ☐ In Transit ☐ Other

Describe: _____

Describe how the incident occurred? _____

_____

_____

What equipment was involved? _____

_____

_____

List at least one thing we can do to prevent similar incidents? _____

_____

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WITNESS INCIDENT REPORT

The purpose of this report is to help prevent similar incidents from recurring. Remember, we are fact finding not fault finding. Please, make this report as accurate and thorough as possible.

Witness Name: _____ Date of Report: _____

Job Title/Occupation: _____ Work Phone: _____

Date of Injury: _____ Time of Injury: _____ AM/PM

Injured Worker: _____

Location of accident (entrance, loading dock, bathroom, etc.): _____

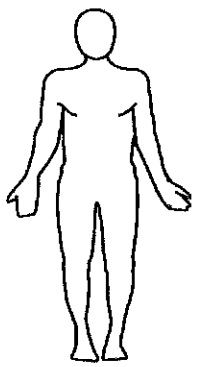
What was the injured worker doing when the incident occurred? _____

How did the incident occur? _____

What body parts were injured? _____

What is at least one thing we can do to prevent this accident from happening again?

Witness Signature: _____ Date: _____



Circle the body parts

WORKERS' COMPENSATION
REFUSAL OF MEDICAL TREATMENT OR OBSERVATION FORM

Employee Name: _____

Location: _____

Today's Date: _____

Brief Description of Injury: _____

_____

I, _____, hereby acknowledge my refusal of medical treatment and/or observation offered to me at the expense of Plymouth Community School Corporation for the work-related injury I incurred on _____.

By signing this form, I realize that it does not necessarily effect my later eligibility for Workers' Compensation.

I acknowledge that my supervisor(s), in good faith, has offered and made available to me an opportunity to seek necessary medical treatment and/or observation. At a later time, I understand that I may request from my supervisor(s) a medical authorization to obtain medical treatment and/or observation for the above described injury; which request can then be either approved or denied.

_____
Employee Signature

_____
Supervisor Signature

Rec'd in Admin Office:

PLYMOUTH COMMUNITY SCHOOL CORPORATION
ON-THE-JOB INJURY CONTACT LIST

Plymouth High School
Jim Condon, Principal (574) 780-6709

Lincoln Junior High School
Reid Gault, Principal (574) 780-4554

Riverside Intermediate School
Kyle Coffman, Principal (574) 933-3165

Jefferson Elementary School
Hope Amor, Principal (574) 248-1298

Memorial Elementary School
Ryan Welch, Principal (574) 780-1110

Washington Discover Academy
Josh Overmyer, Principal (574) 536-7464

Webster Elementary School
Brooke Busse, Principal (574) 210-5709

Food Services Director
Amy Kraszyk, Director (574) 274-9169

Technology Department
Ted Fisher, Director (574) 276-7272

Maintenance Department
Dave Schoof, Director (574) 780-0993
Troy Amor, Assistant Director (574) 335-9035

Transportation Department
Ted Brown, Director (574) 780-5952
Alan Hall, Assistant Director (574) 767-0699

SAINT JOSEPH HEALTH SYSTEM
MEDICAL GROUP

Saint Joseph Health System Immediate Care

Section 1 – Authorization

Today's Date_____ Employee _____

Date of Injury (If applies) _____ SS# _____

Injury Date (If applies) _____ Date of Birth_____

Employee Pays Cash for Services_____

Section 2 – Exams/Physicals

_____ DOT Physical

_____ Pre-Placement Physical (Non-DOT)

_____ Evaluation of Work-Related Injury/Illness

Section 3 – Drug Screen: Check One Box for each

Reason for Testing:

_____ Pre-Employment _____ Reasonable Suspicion _____ Random

_____ Follow-up _____ Post-Accident _____ Return to Duty

Type of Test:

DOT: (Circle Agency) FMCSA, FAA, FRA, FTA, PHSMA, USCG

_____ Use Immediate Care COC _____ COC on File _____ Patient will bring COC

Non-DOT: (Send Out)

_____ 5 Panel _____ 10 Panel + MDMA + OXY + ALC _____ Patient will bring COC

_____ 10 Panel _____ 10 Panel + MDMA + Nicotine + CRT

Instant:

_____ 6 Panel _____ 10 Panel

Section 4 – Breath Alcohol Testing

_____ Pre-Employment _____ Reasonable Suspicion

_____ Random _____ Follow-Up

_____ Post-Accident _____ Return to Duty

Section 5 – Other Testing

_____ Tetanus Vaccine _____ TB Testing

Manager/Supervisor Signature Required

Company Plymouth Community School Corp

Address 611 Berkley Street

City/State/Zip Plymouth, IN 46563

Phone (574) 936-3115

Email emangus@plymouth.k12.in.us

Name (Print) _____

Signature _____

If Injury – Bill To and Claim # Z139670001

The Zenith Insurance Company

Fax: 800-364-0443

Saint Joseph Health System Immediate Care

1919 Lake Ave., Suite 102 • Plymouth, IN 46563

Phone: 574-335-5220 • Fax: 574-335-0859

Hours: Monday-Friday 9:00am-7:00pm

Saturday, 9:00am - 12:00pm • Last Drug Screen registered at 3:00pm