

**RED CLAY CONSOLIDATED SCHOOL DISTRICT  
PRELIMINARY REPORT FOR WORKERS' COMPENSATION  
CLAIM**

**NOTE: ALL INFORMATION MUST BE COMPLETED.** This form must be submitted to Ms. Michele Hartnett, Red Clay Consolidated School District, Workers Compensation Office, 1502 Spruce Avenue, Wilmington, DE 19805, within five calendar days of the injury. If not, the Industrial Accident Board imposes a fine for late reporting. This amount will be charged against the budget of the school/department.

If *all* information is not filled in, and the Workers' Compensation office can't obtain the missing information from the school/department in time to meet the deadline, any fine imposed will be charged against the budget of the school/department.

\*\*Please print legibly.

1. Injured employee's name: \_\_\_\_\_
2. Injury date: \_\_\_\_\_ Injury time: \_\_\_\_\_
3. Place of injury: \_\_\_\_\_  
*If not on Board property, list the exact address including street number & name, city, state and zip.*
4. Date employee knew of the injury: \_\_\_\_\_
5. Normal starting time for this employee: \_\_\_\_\_
6. Date of return to work: \_\_\_\_\_ (indicate if still out or if no time was lost)
7. Date employer was informed of the accident/injury: \_\_\_\_\_
8. Was injury/illness witnessed? Yes \_\_\_\_\_ No \_\_\_\_\_ If answer is yes, provide name and contact number of witness.  
\_\_\_\_\_  
\_\_\_\_\_
9. What was the employee doing when injured?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
10. Was she/he using tools? \_\_\_\_\_ If yes, what tools?  
\_\_\_\_\_  
\_\_\_\_\_
11. Was she/he using the equipment properly or as instructed? Yes \_\_\_\_\_ No \_\_\_\_\_ (If no, explain. \_\_\_\_\_  
\_\_\_\_\_

12. How did the injury occur? Be specific. If necessary type the response on a separate page and attach to this form.

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13. Do you or the principal/supervisor believe the injury was caused by a mechanical defect? YES \_\_\_\_\_ NO \_\_\_\_\_ (YOU MUST ANSWER YES OR NO). If yes, save the piece of equipment until you are contacted by someone from PMA Management Corporation. In the interim do not allow anyone to touch it or use it. *If you are not the principal/supervisor, be sure you inform the person in charge of the above requirement.*

14. Does anyone think the injury was caused by an unsafe act? YES \_\_\_\_\_ NO \_\_\_\_\_ You must answer either YES or NO. If your answer is yes, list the names and locations of witnesses or the person who thinks there was an unsafe act.

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15. Did any amputation result from the injury/accident? YES \_\_\_\_\_ NO \_\_\_\_\_

16. What part of the body was injured? (Be specific) \_\_\_\_\_  
If extremities, list either right or left.

17. What was the nature of the injury? Cut, burn, sprain, etc. \_\_\_\_\_

18. Name and address of the attending physician, emergency room or hospital.

PHYSICIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

TELEPHONE: \_\_\_\_\_

EMPLOYEE SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**NAME AND TITLE OF PERSON SUBMITTING THIS FORM:**

**WORK**

**LOCATION:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**DATE REPORT IS SUBMITTED:** \_\_\_\_\_

**First aid notes:**

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**FAX THIS REPORT TO :** Michele Hartnett 302-992-7824

**SEND ORIGINAL TO:** Michele Hartnett  
Red Clay Consolidated School District  
Workers' Compensation Office  
1502 Spruce Avenue  
Wilmington, DE 19805

**IF YOU HAVE ANY QUESTIONS, PLEASE CALL MICHELE HARTNETT @ 302-552-3812**