NBSIA
PARTNERS IN SERVING SCHOOLS

Injured Worker Intake Sheet

Today's Date: _____ District: _____

District Contact Info: _____ Phone Number: _____

Employee Information (if different than what was reported to Company Nurse):

Employee: _____ Date of Injury: _____

SSN: _____ DOB: _____ DOH: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____

Occupation: _____

Contract Dates (Start/Stop): _____ Employee Status: ☐ FT ☐ PT ☐ SUB

Work Hours (Ex: 8:00am - 5:00pm): _____ Hourly Wage: _____

Work Days: ☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat

Eligible for Education Code Benefits: ☐ Yes ☐ No

Does the Employee work summer months: ☐ Yes ☐ No

Full Day of Regular Pay on Day of Injury: ☐ Yes ☐ No If No, how many hours paid: _____

Pre-existing permanent work restrictions/accommodations: _____

Injury Information:

Work Site: _____

Injury Location (if different): _____

Supervisor's Name: _____ Phone Number: _____

Supervisor's Email: _____

Pre-designated Physician: _____

Employer Information:

☐ Wage history attached for 12 months prior to injury date ☐ Work calendar attached ☐ Job description attached

Are there scheduled or reasonably anticipated wage increase(s)? ☐ Yes ☐ No

If Yes, Effective Date: _____ Hourly Wage: _____

Notes: _____

_____

_____

Form submitted to NBSIA on: _____ By: _____