FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT
PO BOX 71267
907 TERMINAL STREET
FAIRBANKS, AK 99707-1267

EMPLOYEE REPORT OF OCCUPATIONAL INJURY OR ILLNESS TO EMPLOYER

Are you seeking medical treatment? ☐ Yes, Continue with this form ☐ No, Complete and submit an Employee First Aid Report

EMPLOYEE: All blocks must be completely filled out

Name: Last	First	Middle	

Mailing Address	Date of Birth	Date of Death (If applicable)

City	State	Zip Code	Last 4 of SSN	Gender
				☐ F ☐ M ☐ U

Telephone No. Primary	Telephone No. Alternate	Marital Status	Number of Dependents
		☐ M-Married ☐ S-Separated ☐ U-Unmarried ☐ K-Unknown	

Date of Injury / Illness	Time of Injury / Illness	Employer ☐ Borough ☐ School District	Department / School Location

Describe Part of Body Affected (i.e., left lower leg, right index finger, etc.)	Union Affiliation	Supervisor's Name

Describe Nature of Injury / Illness (i.e., sprain, laceration, etc.)	Occur on Employer's Premises? ☐ Yes ☐ No	Supervisor's Contact Number

Was This An Assault? (If applicable) ☐ Yes ☐ No

Definition of an assault: Any willful attempt or threat to inflict injury upon the person of another, when coupled with an apparent present ability to do so, and any intentional display of force such as would give the victim reason to fear or expect immediate bodily harm.

Describe How the Injury / Illness Happened

Witness Name / Contact Number	Witness Name / Contact Phone Number

Initial Treatment

- ☐ Minor Clinic/Hospital Remedies and Diagnostic Testing
- ☐ Emergency Evaluation, Diagnostic Testing, and Medical Procedures
- ☐ Hospitalization Greater than 24 Hours
- ☐ Future Major Medical/Lost Time Anticipated

Physician Name

Medical Facility Name

Employee Authorization to Release Medical Records

To all health care providers:
You are authorized to provide my employer, its workers' compensation liability insurance company, and its claims adjuster information concerning any health care advice, testing, treatment, or supplies provided to me for the injury or illness described above. This information will be used to evaluate my entitlement to receive benefits, including payment of medical benefits, under the Alaska Workers' Compensation Act. This authorization is valid for a one-year period from the date of my signature. I know I have a right to receive a copy of this authorization and agree a photographic copy of this authorization is as valid as the original.

Employee Signature/Digital Signature/Print: **Date Signed:**

If Employee Unavailable to sign, Explain Circumstances in this Space	Date Signed

WARNING TO EMPLOYEES AND EMPLOYERS: AS 23.30.250 imposes civil penalties for fraud as well as certain false or misleading statements and acts. Criminal penalties for theft by deception (including fines and incarceration) apply to knowingly made false statements, claims, or employee misclassifications.

ORIGINAL TO RISK MANAGEMENT IMMEDIATELY & NOTIFY SUPERVISOR **EMPLOYEE KEEP A COPY**

EMPLOYER: File the complete First Report of Injury (FROI), form 07-6101, with the Alaska Division of Workers' Compensation by electronic data interchange (EDI), or by mail, within 10 days of receiving this report, per AS 23.30.070(a).

EMPLOYEES SEND COMPLETED FORMS TO:

EMAIL: ***ReportClaims@fnsb.gov***
MAIL TO:
Fairbanks North Star Borough Risk Management
P.O. Box 71267 Fairbanks, AK 99707
FAX: **(907) 459-1187**
HAND DELIVER: **907 Terminal Street, 3rd Floor, Risk**
Interoffice or mailbag address: FNSB/Risk Mgt.

Claims Adjuster Use Only

FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT
FITNESS FOR DUTY

☐ Non-work related injury or illness

Note to Supervisor and Employee: Employee is not allowed back on the job site until this form has been reviewed and approved for return to work. Human Resources will contact the supervisor to facilitate the review and approval process. **Fax this form to (907) 451-6008 or hand-deliver form to Human Resources.**

☐ Workers' Compensation

Note to Supervisor and Employee: Treating employee is not allowed back to duty until Risk Management has reviewed and approved their return to work. The Claims Adjuster will contact the supervisor to facilitate the review and approval process. **Fax completed form to (907) 459-1187 or hand deliver to FNSB Risk Management within one day of your appointment.**

Employee Work Status (Fitness for Duty)

Employee Name: _____

☐ **Unable** to return to work until _____

☐ Can return to **full work** with no restrictions on: _____ (Please mark restrictions below)

☐ Can return to **modified work** on: _____ adhering to **restrictions** checked below:

Physical Capacity Restrictions

All sections must be completed by treating physician

NOTE: **OCCASIONALLY** (UP TO 2 HOURS PER 8-HOUR DAY) **FREQUENTLY** (UP TO 4 HOURS PER 8-HOUR DAY)

Lift/Carry	Not At All	Occasionally	Frequently	No Restrictions
0 – 3 lbs.	_____	_____	_____	_____
4 - 10 lbs.	_____	_____	_____	_____
11 - 20 lbs.	_____	_____	_____	_____
21 - 40 lbs.	_____	_____	_____	_____
Over 40 lbs.	_____	_____	_____	_____
Able To Do				
Bending	_____	_____	_____	_____
Squatting	_____	_____	_____	_____
Climbing	_____	_____	_____	_____
Pushing/Pulling	_____	_____	_____	_____
Kneeling	_____	_____	_____	_____
Reach above shoulder	_____	_____	_____	_____
Repetitive hand motion	_____	_____	_____	_____
Stand	_____	_____	_____	_____
Walk	_____	_____	_____	_____
Sit	_____	_____	_____	_____
Drive	_____	_____	_____	_____

_____ Right _____ Keep wound/dressing clean & dry _____ Use assistive devices: sling, brace, crutches

_____ Left _____ Avoid contact with chemicals _____ can do data entry _____ hours at a time

Other: _____

Describe how any prescribed medications would adversely affect the performance of essential job functions:

_____

Follow-Up Care

_____ Final visit, discharge from care for this injury/illness Re-Evaluation on _____

_____ Physical Therapy prescribed: Frequency _____ Duration _____

Comments: _____

Physician Printed Name: _____ Date: _____

Physician Signature: _____ Date: _____

Human Resources' Signature: _____ Date: _____