

### CITY OF DUBLIN EMPLOYEE'S BACK INJURY REPORT

**THIS FORM IS TO BE COMPLETED AND SIGNED BY EMPLOYEE WHEN BACK INJURY IS REPORTED.**

Employee Name: \_\_\_\_\_

1. What part of your back hurts now? \_\_\_\_\_

2. When did you first notice the back pain? \_\_\_\_\_

3. What were you doing at the time of injury (explain in detail)? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. If you were lifting an object, what was it and how heavy? \_\_\_\_\_

\_\_\_\_\_

5. What was your exact position when pain was first noticed? \_\_\_\_\_

6. What did you feel? \_\_\_\_\_

7. What was the length between the injury and your disability? \_\_\_\_\_

8. Did anyone see you get hurt? (Circle) Yes No If so, give name: \_\_\_\_\_

9. Did you report or mention this injury to anyone? (Circle) Yes No

If so, who and when? \_\_\_\_\_

10. Did you ever hurt your back before? (Circle) Yes No

If so, when? \_\_\_\_\_ What part of your back? \_\_\_\_\_

Were you treated by a doctor? (Circle) Yes No If so, date: \_\_\_\_\_

Has it given further trouble? (Circle) Yes No If yes, explain: \_\_\_\_\_

11. Have you ever received or filed for compensation because of a back injury? (Circle) Yes No

Other injury? (Circle) Yes No

If so, list Bureau of Workers' Compensation claim number(s) \_\_\_\_\_

#### MEDICAL RELEASE

I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to disclose such information to my employer, the Third Party Administrator or the Managed Care Organization and employer designated representative. A copy of this form will serve as the original.

Employee Name (Print) \_\_\_\_\_

Employee Signature \_\_\_\_\_ Date (required) \_\_\_\_\_