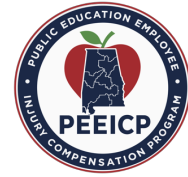
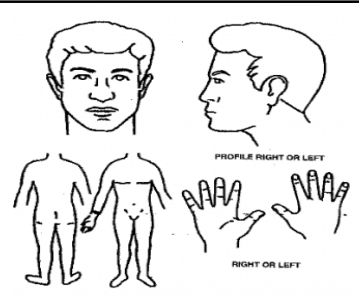




STATE OF ALABAMA

**Public Education Employee Injury
Compensation Board**Form FR-1
(Rev. 2026)**First Report of Injury****Please Submit This Form Along with the Employee's Accident Report Immediately.****PEEICB@MRM-LLC.COM or Fax: (205) 777-6097**

1. Name of Injured Employee Last _____ First _____ MI _____		2. SSN ____ - ____ - ____	3. Date of Birth ____ / ____ / ____	4. Sex ☐ M ☐ F																		
5. Employee Mailing Address No. and Street _____ City or Town _____ State _____ Zip _____		6. Employee Phone Home _____ Cell _____ Work _____ Employee Work Hours: From: _____ To: _____ Normal Scheduled Days Off: ☐ MO ☐ TU ☐ WE ☐ TH ☐ FR ☐ SA ☐ SU																				
7. Job Title _____		8. Employee Email address _____																				
9. Employment Status ☐ Full Time ☐ Part Time ☐ Adult Bus Driver		10. Employer _____																				
11. School District _____		12. Employer Address City or Town _____ State _____ Zip _____																				
13. Date of Injury ____ / ____ / ____	14. Date Employer Notified ____ / ____ / ____	15. Time of Injury ____ : ____ ☐ AM ☐ PM	16. On Employer's Premises? ☐ Yes ☐ No																			
17. Health Insurance Coverage PEEHIP ☐ VIVA ☐ Other ☐																						
18. Has the injury or illness resulted in medical treatment? ☐ Yes ☐ No																						
If yes, name and address of medical provider/facility. _____ _____																						
19. Exact location where injury occurred include street address, building, room, parking lot, etc., if possible. _____ _____																						
20. Was injury caused by a motor vehicle accident? ☐ Yes ☐ No If yes, provide copy of police report to PEEICB.																						
21. Was more than one person injured in this incident? ☐ Yes ☐ No If yes, provide name(s): _____																						
22. Describe exactly what the injured employee was doing and how the accident occurred. _____ _____ _____ _____ _____																						
23. Describe the injury (ies) received. Indicate if cut, bruise, sprain, strain, twist, pull, etc. (Give details below): _____ _____ _____ _____ _____ _____ _____				Indicate the body part(s) affected below and by circling on the body chart at left. <table style="width:100%;"><tr><td>☐ Head</td><td>☐ Eye(s)</td></tr><tr><td>☐ Left Arm</td><td>☐ Right Arm</td></tr><tr><td>☐ Left Hand</td><td>☐ Right Hand</td></tr><tr><td>☐ Left Leg</td><td>☐ Right Leg</td></tr><tr><td>☐ Back</td><td>☐ Neck</td></tr><tr><td>☐ Left Foot</td><td>☐ Right Foot</td></tr><tr><td>☐ Left Knee</td><td>☐ Right Knee</td></tr><tr><td>☐ Left Ankle</td><td>☐ Right Ankle</td></tr><tr><td colspan="2">☐ Other _____</td></tr></table>	☐ Head	☐ Eye(s)	☐ Left Arm	☐ Right Arm	☐ Left Hand	☐ Right Hand	☐ Left Leg	☐ Right Leg	☐ Back	☐ Neck	☐ Left Foot	☐ Right Foot	☐ Left Knee	☐ Right Knee	☐ Left Ankle	☐ Right Ankle	☐ Other _____	
☐ Head	☐ Eye(s)																					
☐ Left Arm	☐ Right Arm																					
☐ Left Hand	☐ Right Hand																					
☐ Left Leg	☐ Right Leg																					
☐ Back	☐ Neck																					
☐ Left Foot	☐ Right Foot																					
☐ Left Knee	☐ Right Knee																					
☐ Left Ankle	☐ Right Ankle																					
☐ Other _____																						
24. Name all witnesses (Use additional paper as necessary): Name _____ Daytime Phone _____ Name _____ Daytime Phone _____																						
I am the supervisor of the employee making the claim for PEEICB benefits and have filled out this First Report of Injury based on the information that has been reported to me. I certify that the above information is true and correct to the best of my knowledge.																						
25. Signature of individual reporting incident _____		Print Name and Email _____		Daytime Phone _____																		
Date _____																						