**Employee Information**

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| --- | --- | --- | --- | --- |
| **Employee Name:** |  |  | **Job Title:** |  |
| **Employee Social Security Number:** |  |  | **Employee Cell/Home Phone:** |  |
| **Supervisor Name:** |  |  | **Location of Incident:** |  |
| **Time work began:** |  |  | **Regular Schedule:** |  |

**Important:** Failure to report occupational injuries in a timely manner and/or failure to comply with the District’s policies for medical treatment of occupational injuries could result in delay of any possible workers’ compensation claim benefits. Workers’ compensation claims may be subject to investigation by the insurance carrier. The employee must be treated by the District’s designated medical facility if a physician was not previously pre-designated. ***Any person who makes or causes to be made any knowingly false or fraudulent material representation for the purpose of obtaining or denying workers’ compensation benefits or payments is guilty of a felony.***

**Incident Information**

**Does this injury require immediate medical attention?**  Yes  No

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date of Incident: |  | | | | | | Date Reported: | | |  | | | Time of Incident: |  | |
| Who was incident reported to? | | | |  | | | | | | | | | | | |
| Were you performing your regular job duties at the time of accident? | | | | | | | | | | | | Yes  No | | | |
| If No, please explain: | | |  | | | | | | | | | | | | |
| Location where incident occurred: | | | | | |  | | | | | | | | |
| Were there any witnesses to the accident? | | | | | | | | Yes  No | | | | | | |
| If yes, please list witness names: | | | | |  | | | | | | | | | |
| Were there any safety hazards, if yes explain: | | | | | | | | Yes  No | | | | | | |
|  | | | | | | | | | | | | | | |
| How did the incident happen? Describe specific activity being performed, including tools, equipment, or materials used: | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| Describe body part(s) affected & how the body part is affected (i.e. bruising, sprain, etc.): | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| Any previous injuries to affected body part(s)? | | | | | | | | | Yes  No | | | | | |
| If yes, please explain: | |  | | | | | | | | | | | | |
| Any previous workers compensation claims: | | | | | | | | | Yes  No | | Details: | |  | |

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| --- |
| Employee Signature |
|  |
| Human Resources Date Received: |