**Employee Information**

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| --- | --- | --- | --- | --- |
| **Employee Name:** |  |  | **Job Title:** |  |
| **Supervisor Name:** |  |  | **School Site:** |  |
| **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**

**Did the employee seek medical care?**  Yes  No

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date of Incident: |  | | | | | | | Date Reported: | | |  | | Time of Incident: |  | |
| Who was incident reported to? | | | | |  | | | | | | | | | | |
| Was the employee performing 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 | | | | | |
|  | | | | | | | | | | | | | | |
| Describe injuries/illnesses which you observed or were described to you: | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| Describe shoes, physical appearance, or other characteristics that would contribute to understanding how the incident occurred: | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| Are there steps to prevent similar incident in the future? | | | | | | | | | | Yes  No | | | | |
| If yes, please explain: | |  | | | | | | | | | | | | |
| Additional Concerns: | | | |  | | | | | | | | | | |

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