

Part 1: To be completed by employee. Fill in all of the blanks.

Employee's full name _____ Social Security# _____ DOB _____ Sex _____
Address _____ City _____ State _____ Zip _____
Home # _____ Work # _____ Job title _____
Location (school, building & area where incident occurred) _____
Date of injury _____ Time of injury _____ a.m./p.m. Scheduled shift: from _____ to _____
Last date worked _____ Return to work date _____ Days missed due to injury _____
Describe what happened in detail (What you were doing? lifting/pushing/pulling, indoors/outdoors, using tools/machinery, chemicals/ fumes)

Body part(s) injured _____ Right / Left

Witnesses to actual incident _____

Date reported to supervisor as work related _____ Reported to _____ Title _____

First aid only? **Yes / No** Seen by a doctor? **Yes / No** **If yes, provide doctor's name, clinic or hospital name, address, city, state, zip, telephone number and date examined below.**

Your employer/school district is a self-insured member of the Southeast Washington Workers' Compensation Trust. If you have or will be receiving treatment at a clinic or hospital for the above incident you need to contact Educational Service District 112 immediately to file a claim for benefits and obtain an SIF2 form. ESD 112 can be reached at 1-800-749-5861 or 360-750-7504. You will need to file a self-insured Physicians Initial Report at the clinic or hospital and have it sent to ESD 112 Workers' Compensation at 2500 NE 65th Ave, Vancouver, WA 98661-6812L.

Employee signature _____ Date _____

Part 2: To be completed by supervisor. Fill in all of the blanks.

Date of injury _____ Date incident reported to you as work related _____

If not reported the same day why? _____

Date incident investigated _____ If equipment/tool damaged describe _____

Employee job title _____ Employee date of hire _____

Shift on date of injury _____ Time employee left work on date of injury _____

Last date worked _____ Return to work date _____ Days missed due to injury _____

Describe incident, specify body part(s) injured _____

Why did the incident occur? _____

What steps were taken to prevent similar incidents? _____

Was incident caused by anyone not on school district payroll? If yes give name, address, and attach a copy of any police reports or in-house school district reports filed. _____

Comments _____

Supervisor signature _____ Date _____

Supervisor printed name, title & telephone # _____



DISTRIBUTION UPON COMPLETION:

Print, fax & mail to ESD112 Workers' Compensation Fax is: (360) 750-9836, address above

Copies to: ESD123 Loss Control 3918 W Court St Pasco WA 99301 Employee Services lklippert@psd1.org