EMPLOYEE INCIDENT REPORT

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

Employee's full name ____________________ 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 __________
Severity of Incident: No injury/Near miss incident: **Yes / No** 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:

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Describe what happened in detail (What you were doing? lifting/pushing/pulling, indoors/outdoors, using tools/machinery, chemicals/ fumes)

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Body part(s) injured ____________________ Right / Left

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Witnesses to actual incident ____________________
Date reported to supervisor as work related __________ Reported to __________ Title __________

Your employer/school district is a self-insured member of the North Central Washington Workers' Compensation Trust (the Trust). If you have or will be receiving treatment at a clinic or hospital for the above incident you need to contact the District Office to obtain an SIF2 form to file a claim for benefits.

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 ____________________

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Supervisor signature ____________________ **Date** __________
Supervisor printed name, title & telephone # ____________________

Send Completed Report to the District Office
Original Copy – Kept in District Office