WARREN
City School District

EMPLOYEE INCIDENT/ACCIDENT REPORT

To Be Completed by Injured Employee

Name: _____ Social Sec. No._____
Home Address: _____ Date of Birth:_____ Sex: ☐ Male ☐ Female
City/State/Zip**:** _____ Telephone: ( ) _____
Title/Position: _____ Department/Building: _____

Accident Location: _____
Date of Injury or onset of symptoms: _____Time: _____ ☐ am ☐ pm

Were you performing regular duties at the time of accident? ☐ Yes ☐ No
Did anyone see you get hurt? ☐ Yes ☐ No If yes, who? _____
Did you report this incident to anyone? ☐ Yes ☐ No If no. why not? _____
If yes, to whom did you report it? _____Title/Position:_____ When:_____

What time did you start work today?_____am/pm
What time was the injury? _____am/pm ☐ Unknown

Please **fully describe** the accident that caused your injury/symptoms: What you were doing just before the Incident, and what you did after the incident. Be specific. Name any objects or substances involved in the incident. Identify injured body part on the attached chart:

_____
_____
_____
_____
_____
_____
_____

What type of injury did you experience and what part(s) of your body was/were affected? (BE SPECIFIC**:** for example. bruise, scrape, laceration, pull / to the right elbow. left knee, right index finger):

_____
_____
_____
_____
_____
_____

Was any first aid provided at the scene? ☐ Yes ☐ No If yes, describe: _____
_____
Provided by: _____

Did you seek other medical treatment? ☐ Yes ☐ No
If yes, When?:_____Where?:_____
If treatment was not sought immediately, explain Why?_ _____
_____

Is this an aggravation of a previous injury/symptom? ☐ Yes ☐ No
If yes, when were you last treated for the previous injury?: By whom or where?: _____
_____
Have you ever had a similar injury? ☐ Yes ☐ No If yes, describe other injury:_____
_____
_____

Explain how the work environment/work practices caused or contributed to the accident:

Please describe the equipment being used at the time of the accident and the affect it had on the accident:

If the incident was related to student interaction: What behaviors/actions would prevent this type of incident in the future?

What specific area of the building/grounds were you in/on and what specific tasks were being conducted at the time of the accident?

How could this type on injury be prevented in the future?

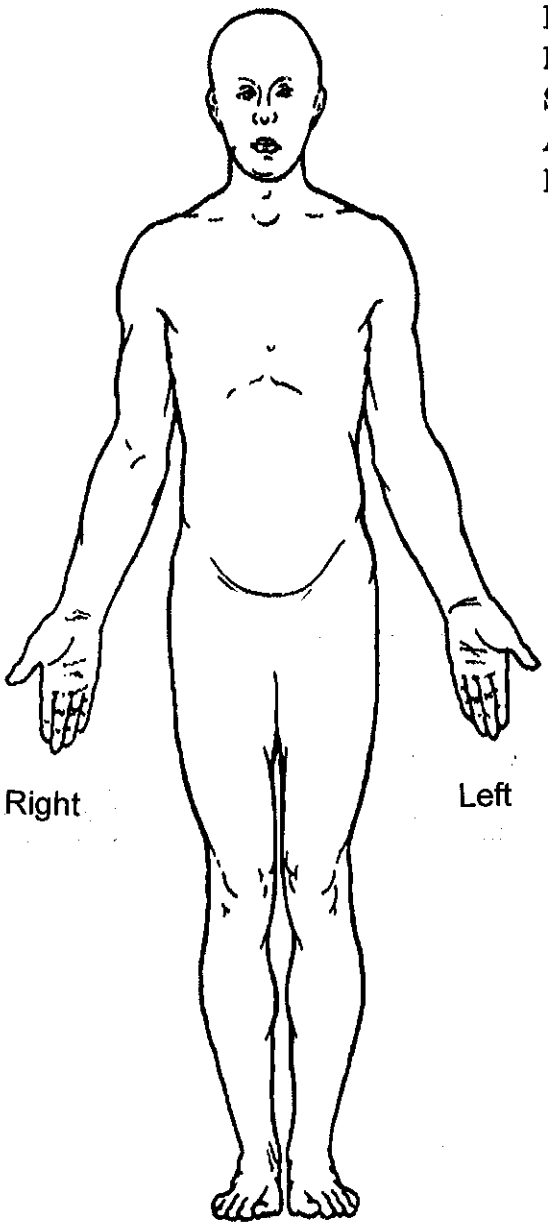
Medical Release -Under current Workers' Compensation Law, the employer is entitled to a signed medical release. I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to disclose such Information to my employer, my employer's managed care organization, or to my employer's designated representative. A copy of this form will serve as the original.

Employee Name (print): _____ **Date (required):** _____

Employee Signature: _____

Please mark the area of injury or discomfort on the chart below using the appropriate symbols:

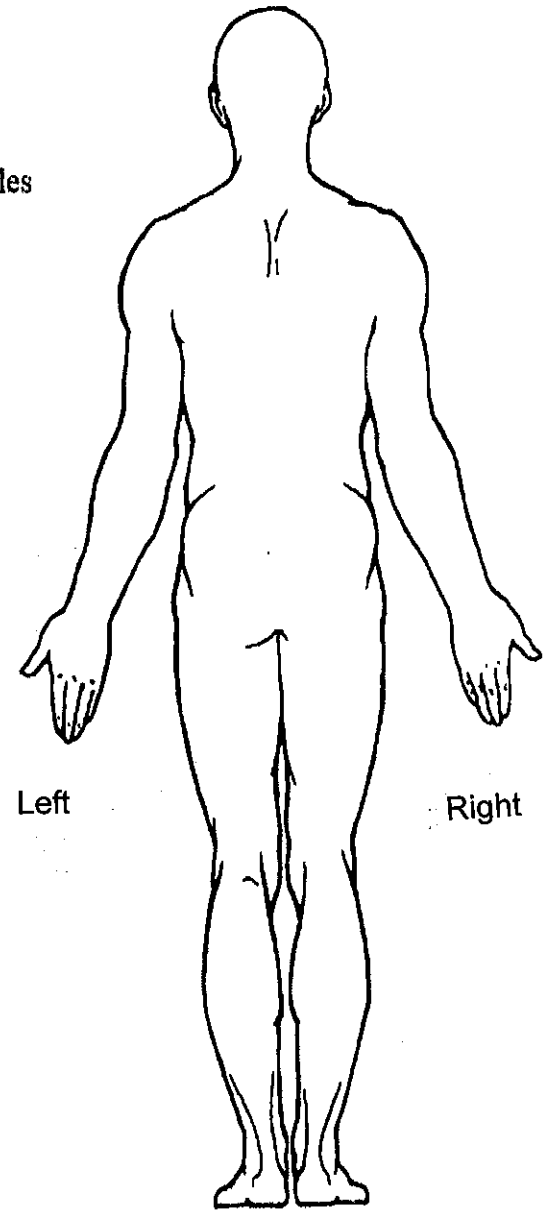
Front



Types of Pain

B = Burning
N = Numbness
S = Stabbing
A = Aching
P = Pins & Needles

Back



Pain Scale

0= No Pain **10= Severe Pain**

Check One: ○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

Employee Name _____ Date of injury _____

Employee Signature _____ Date _____

WARREN
City School District

STATEMENT OF WITNESS TO INCIDENT

I. INCIDENT IDENTIFICATION INFORMATION

Name of Employee alleging incident: _____

Title/Position: _____ Department: _____

Date of Incident: _____

II. WITNESS STATEMENT

Your name has been given as a witness to an incident alleged by the above individual. Through your cooperation, information can be obtained to complete the investigation of this incident. Therefore, it will be appreciated if you will answer each of the following questions and promptly return your completed statement.

Your Name: _____ Your Title/Position: _____

Department: _____

Did you witness the incident?
If not, how did you learn about the incident?

_____

_____

If you did see an incident occur: Date of incident: _____
Time of incident: _____AM/PM

Describe what you witness:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Print Your Name: _____

Your Signature: _____ Date: _____

WARREN CITY SCHOOLS

SUPERVISOR'S INVESTIGATION REPORT

Employee Name: _____ **Date of Injury:** _____ **OSHA Log #**_____

OSHA 301 Info in Bold

Was the employee killed as a result of the accident? If yes, indicate date of death:_____

Were there any witnesses to this injury? □ **Yes** □ **No**
If yes, witness statements should be attached.

Was the injury a result of horseplay, under the influence of drugs, or purposely self-inflicted? □ **Yes** □ **No**
If yes, please specify details on the back of this form or on another page.

Has there been any recent disciplinary action taken against this employee? □ **Yes** □ **No**
If so, please describe:

_____

_____

Has the employee submitted medical documentation for the injury? If so, please attach. □ **Yes** □ **No**

Was the employee treated in an emergency room or similar? □ **Yes** □ **No**

Was the employee hospitalized overnight as an in-patient? □ **Yes** □ **No**

If known, please provide us with the name, address and telephone number of attending physician and/or hospital:

Physician:_____

Facility:_____

_____

_____

_____

_____

Has the employee returned to work? □ **Yes** □ **No**
Last Day worked _____ Returned to work _____

Does the employee have restrictions to duty? □ **Yes** □ **No** Applicable dates:_____

Is the employee performing their full duties? □ **Yes** □ **No**

Was the employee given a prescription by the physician? □ **Yes** □ **No**

Employee Date of hire: _____

Have the conditions that caused the accident been controlled? □ **Yes** □ **No**

Describe action taken to prevent the accident in the future:_____

_____

With the information you have, would you recommend the claim be accepted? □ **Yes** □ **No**

If no, why? _____

Completed by:

_____ _____
Supervisor Signature/Title/Phone Date

_____ _____
Workers' Compensation Coordinator Signature Date

**Please attach completed incident reports, witness statements and any accumulated medical bills and information. Additional comments may be noted on the reverse side.