EMPLOYEE INCIDENT REPORT

PART I: *To be completed by* EMPLOYEE Revised October 2021

If you seek medical treatment, call ESD 113 Workers' Compensation Trust at 360-464-6880 to file a claim

Incident Date_____ Hour _____ am/pm Work Phone _____

School District _____ School Name _____

Employee's Name _____ Social Security Number _____

Address _____ City _____ Zip _____

Home Phone _____ Date of Birth _____ Marital Status / Dependents _____

Department _____ Job Title _____ Shift Hours _____ to _____
(Food Service, Transportation, Maintenance, etc.)

Please mark the applicable category with an X:

____Have not received first aid or medical treatment at this time, but may want to file a claim at a later date.

____Received first aid (If YES, please describe type and by whom) _____

____Will or have received medical treatment (Phone 360-464-6880 to file claim for and add information below):

_____
If receiving medical treatment complete: (Medical Provider's Name / Clinic / Hospital) (Phone Number) (City)

Reported the Incident to _____ Date Reported _____

Name(s) of Witness(es) _____

Did Incident Occur On or Off School Premises? _____ Were You Doing Your Regular Work? _____

Where Did Incident Occur? _____
(Breezeway, classroom, garage, grounds, etc.)

Description of Incident (include task being performed; step by step detail of incident; any tool/object involved): _____

_____

_____

Injury _____ Body Part Injured _____ RIGHT or LEFT
(Bruise, sprain, strain, wound, etc.)

EMPLOYEE SIGNATURE _____ DATE _____

PART II: *To be completed by* the SUPERVISOR

Date Investigated _____ Equipment Damaged? YES or NO If yes, describe: _____

Describe incident per your findings: _____

_____

Could the incident have been prevented? YES or NO If yes, how? _____

Describe what was found unsafe (Employee actions, equipment, lighting, clutter etc.) _____

_____

Follow up action to be taken _____ By whom _____ Date _____

Last date worked _____ Return to work date _____ Is light duty work available? YES or NO

SUPERVISOR SIGNATURE _____ Phone # _____ Date _____

Fax completed copy to ESD 113 Workers' Comp. Trust FAX #: 360-464-6907

(Please make copies for your DISTRICT OFFICE & SAFETY COMMITTEE as needed)

ON-THE-JOB INJURY CLAIMS FILING PROCEDURE

When You Have An On-The-Job Accident:

- ✓ Obtain needed first aid or emergency medical treatment
- ✓ Report the accident to your supervisor and give them your Employee Incident Report as soon as you have your portion completed
- ✓ if you seek medical treatment, phone Capital Region ESD 113 Workers' Compensation Trust at 360-464-6880
- ✓ Ask your medial care provider to fax a Provider's Initial Report (PIR) to Workers' Compensation at 360-464-6907
- ✓ Advise each medical care provider of your employer's self-insured status. All reports and bills should be faxed to 360-464-6907 or mailed to:
  - Capital Region ESD 113 / Workers' Compensation Trust
  - 6005 Tyee DR SW
  - Tumwater, WA 98512
- ✓ Follow your medical provider's instructions for a speedy and complete recovery

NOTICE: If You Seek Treatment From A Medical Care Provider

An injured worker must see a network provider for any care beyond an initial office or emergency room visit. This applies to any care within Washington State from the following types of providers: physicians, chiropractors, naturopathic physicians, podiatric physicians and surgeons, dentists, optometrists, advanced registered nurse practitioners, and physician assistants

- ❖ L&I manages the network
- ❖ Workers can choose any provider in the network for ongoing care. To determine if a provider is in the network, you may simply ask the provider or check online at http://www.lni.wa.gov/claimsins/claims/findadoc/
- ❖ Only for the initial office or emergency room visit, may workers be seen by a non-network provider