Prosser School District

EMPLOYEE INCIDENT REPORT

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 Southwest 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 Trust at Educational Service District 112 to file a claim for benefits and obtain an SIF2 form. The Trust 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.***

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 # _____

Part 3: To be completed by district office. Fill in all of the blanks.

Hours worked each day _____ Days worked per year _____ Hourly wage at time of injury_____
District office signature _____ **Date** _____

WHITE to ESD112 **YELLOW** to district office **PINK** to employee EIR 4156