Incident Report

The top portion of this report is to be completed by the employee/volunteer/visitor at the time of the incident. The bottom portion is to be completed the on-duty supervisor or building administrator on the same day as the accident. Send to the business manager.

Filing an Incident Report does not constitute a Workers' Compensation claim. Injured employees/volunteers/visitors who go to the doctor after an Incident Report and Pain Diagram is filed must immediately notify the district that they required medical treatment beyond first aid.

Employee/Volunteer/Visitor

Name of Employee/Volunteer/Visitor: _____ Gender: ○ Male ○ Female

Job Title: _____

District _____ Department: _____

Work Shift: _____

Date of Incident: _____ Time of Incident: _____ ○ am ○ pm

Incident Location: _____

Reported to: _____ Phone: _____ Staff: ○ Yes ○ No

Witness: _____ Phone: _____ Staff: ○ Yes ○ No

Witness: _____ Phone: _____ Staff: ○ Yes ○ No

First Aid Given? ○ Yes ○ No

If yes, please indicate the type of first aid:

☐ Ice ☐ Observed ☐ Washed Wound ☐ Applied Splint ☐ Kept Immobile ☐ Applied Dressing ☐ Stopped Bleeding ☐ Other: _____

Do you require medical treatment beyond first aid? ○ Yes ○ No

If yes, you must complete form 801 in addition to the Incident Report and Pain Diagram.

Body Part(s) Injured: Indicate your injuries below. **Also complete attached Pain Diagram.**

HEAD	TRUNK	EXTREMITIES		OTHER
☐ Ear	☐ Abdomen	☐ Ankle	☐ Lower Arm	☐ _____
☐ Eye	☐ Back	☐ Elbow	☐ Lower Leg	☐ _____
☐ Face	☐ Chest	☐ Finger	☐ Thumb	☐ _____
☐ Head	☐ Groin	☐ Foot	☐ Toes	☐ _____
☐ Neck	☐ Shoulder	☐ Hand	☐ Upper Arm	☐ _____
☐ Scalp	☐ Trunk	☐ Knee	☐ Wrist	☐ _____

SUSPECTED NATURE OF INJURY:

☐ Laceration/Abrasion ☐ Bruise/Contusion ☐ Fracture ☐ Burn ☐ Other: _____ ☐ Sprain/Strain ☐ Concussion ☐ Dislocation ☐ Surface Cut/Scratch

SUSPECTED CAUSE OF INJURY:

☐ Fall/Slip ☐ Push/Pull ☐ Lifting ☐ Other: _____

Describe how incident occurred, including events that occurred immediately before the accident: *(Field limited to 3 lines of text.)*

I certify, as attested by my signature below, that all information I have given is true and contains no false statements and/or misrepresentations.

Print Employee/Volunteer Name: _____

Employee Signature: _____ Date: _____

Supervisor

Date Reported: _____ Time: _____ ○ am ○ pm To Whom? _____

Were other workers injured? ○ Yes ○ No *If yes, please name:* _____

Additional Comments: *(Field limited to 2 lines of text.)*

I certify, as attested by my signature below, that all information I have given is true based on my knowledge of the incident.

Print Supervisor Name: _____

Supervisor Signature: _____ Date: _____

Pain Diagram

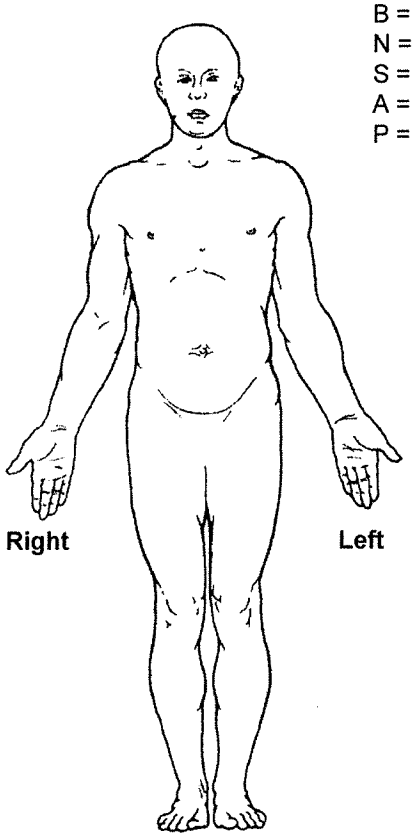
Please complete the Pain Diagram and submit along with the completed **Incident Report** or **Form 801**, or both.

Please Note: Completion of the Pain Diagram is voluntary and is not required to apply for workers' compensation benefits.

Name: _____ Employer: _____

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

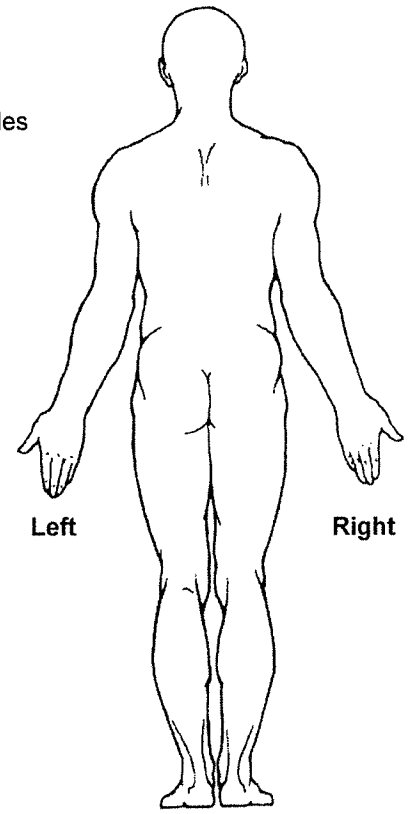
Front



Type 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

Please use the space below to describe your condition further, if needed:

I certify, as attested by my signature below, that all information I have given is true and contains no false statements and/or misrepresentations.

Print Worker's Name: _____

Worker's Signature: _____ Date: _____