Pasco School District **ESD 123** **EMPLOYEE INCIDENT REPORT**
(insert school district name here)

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 Southeast Washington Workers' Compensation Trust. If you have or will be receiving treatment at a clinic or hospital for the above incident you need to <u>contact Educational Service District 112 immediately</u> to file a claim for benefits and obtain an SIF2 form. ESD 112 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 and have it sent to <u>ESD 112 Workers' Compensation at 2500 NE 65th Ave, Vancouver, WA 98661-6812l</u>.*

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 # _____

DISTRIBUTION UPON COMPLETION:
<u>*Print, fax & mail* to ESD112 Workers' Compensation</u> Fax is: (800) 831-0175, address above
Copies to: ❑ Business Office ❑ ESD123 Loss Control 3918 W Court St Pasco WA 99301 ❑ Human Resources
mmadrigal@psd1.org, mgray@psd1.org, scluck@esd123.org, rnunamaker@psd1.org