FREMONT UNION HIGH SCHOOL DISTRICT

WORKER'S COMPENSATION - EMPLOYEE INCIDENT/INJURY

PART I: TO BE COMPLETED BY EMPLOYEE

Name: SSN:

Home Address: Phone:

Sex: Job Title: Dept./Site:

To whom did you report this incident?: Date of injury: Time of incident:

Time you begin work: AM/ PM

Were you unable to work at least one full day after injury? (circle one) Yes/No

If yes, date last worked _____

Have you returned to work? (circle one) Yes/No

If yes, date returned: _____

Body part injured(be specific)

Have you gone or are you planning to go to the a doctor?

If yes, provide name & address of doctor:

Date you reported incident: Location of incident:

How did incident occur? Be specific & detailed.

Employee's Signature: Date:

PART II: TO BE COMPLETED BY SUPERVISOR/PRINCIPAL

Type of Incident: (choose one) ☐ Injury ☐ Illness ☐ Near Miss

Incident Date:

Where did the injury occur?

Date employee reported incident:

Did incident occur on school premises? (circle one) Yes/No

Under School jurisdiction? (circle one) Yes/No

Safety Rule(s) Violated? (circle one) Yes/No

Was the employee working within his/her job description? (circle one) Yes/No

Describe the incident (How, why & what happened. Include step-by-step detail of incident.)

What caused the incident?

Name(s) of witness(es) & phone #s:

Describe immediate corrective action, the date immediate corrective action was complete & by whom:

Supervisor's/Principal's Signature: Date:

Please make three (3) copies: one for the District; one for the Employee; and one for the Safety Director/Committee