HAMILTON-WENHAM
REGIONAL SCHOOL DISTRICT

WORK RELATED INJURY PROCEDURES AND REPORTING FORM

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Hamilton Wenham Regional School District provides a workers' compensation insurance program at no cost to its employees. This insurance program can provide wage replacement and medical benefits to employees injured during the course of employment.

1. All employee injuries should be reported on a First Report of Injury Report by the injured employee and/or their Supervisor and submitted to the Human Resources Department within 24 hours. Human Resources will determine the appropriate course of action, and file any relevant claims for workers' compensation. No matter how minor a work-related injury may appear, it is important that it be reported as promptly as possible. Please fill out every question and have this signed by your supervisor.

2. Injured employees should seek necessary medical care or treatment, and should inform their medical care provider that the injury or illness is work-related. If the employee is seriously injured and cannot be moved, the Supervisor or an appropriate staff member should call for an ambulance.

3. Employees should not perform tasks that are not detailed in their job descriptions, such as moving furniture and appliances or snow shoveling.

4. While out of work due to a work-related injury, voluntary benefits (such as group medical insurance) will remain in effect if the employee makes arrangements through the District Accountant to continue paying their contribution to the District.

EMPLOYER'S FIRST REPORT OF INJURY

NAME: _____ **SOCIAL SECURITY#** _____

ADDRESS ST: _____ **TELEPHONE: (h)** _____

CITY, ST, ZIP: _____ **TELEPHONE: (w)** _____

MARITAL STATUS: ☐ Single ☐ Married **SEX:** ☐ Male ☐ Female

DATE OF HIRE: _____ **DATE OF BIRTH:** _____

OCCUPATION: _____ **DEPARTMENT:** _____

AVG WEEKLY WAGE: $ _____ **NUMBER OF DEPENDENTS:** _____

DATE OF INJURY: _____ **LOCATION INJ OCCURRED:** _____

Time of Injury: _____ **WITNESS TELEPHONE:** _____

Time of Day they started Work: _____ **THEIR POSITION:** _____

please answer all of the questions below:

WITNESS: _____

WAS TIME FROM WORK LOST? ☐ Y ☐ N

TO WHOM WAS THE INJURY REPORTED

MEDICAL TREATMENT SOUGHT? ☐ Y ☐ N

_____

DATE INJURY WAS REPORTED: _____ **MEDICAL FACILITY:** _____

DATE RETURNED TO WORK: _____ **RETURNED TO WORK?** ☐ Y ☐ N

LOCATION WHERE INJURY OCCURRED: **SOURCE OF INJURY:** (fall, machinery, chemicals)

_____ _____

BODY PART(S) INJURED: _____ _____

EMPLOYEE SIGNATURE

DESCRIPTION OF INJURY: _____

_____

_____

WHAT CAUSED THE UNSAFE CONDITION? _____

_____

WAS SAFETY GEAR BEING WORN ☐ Y ☐ N **IF NO, SHOULD IT HAVE BEEN:** ☐ Y ☐ N

WAS ACTION TAKEN TO PREVENT A SIMILAR ACCIDENT IN THE FUTURE ☐ Y ☐ N **IF YES, EXPLAIN** _____

_____

DATE CENTRAL OFFICE WAS NOTIFIED: _____ **WHO WAS NOTIFIED?** _____

EMPLOYER REMARKS: _____

_____

EMPLOYER'S REP NAME: _____ **TITLE:** _____

EMPLOYER'S REP SIGNATURE: _____ **DATE PREPARED:** _____