Grand Coulee Dam School District EMPLOYEE INCIDENT REPORT

Part 1: To be completed by employee.	Fill in all of the blanks.	
Employee's full name	Social Security# City #Job title	DOB Sex
Address	City	State Zip
Home # Work #	#Job title	
Location (school, building & area where incident occu	nred) a.m./p.m. Scheduled to work date Days missed due	
Date of injury Tim	ne of injury a.m./p.m. Scheduled	shift: from to
Last date worked Return	to work date Days missed due	e to injury
	were doing? lifting/pushing/pulling, indoors/outdoors, using	g tools/machinery, chemicals/ fumes)
Body part(s) injured		Right / Lef
Witnesses to actual incident		
Date reported to supervisor as work related	d Reported to	Title
First aid only? Yes / No Seen by a doct city, state, zip, telephone number and date	tor? Yes / No If yes, provide doctor's nam examined below.	e, clinic or hospital name, address,
	nsured member of the North Central Was e receiving treatment at a clinic or hospita	
Trust (the Trust). If you have or will be to contact the Trust at NCESD 171 to fil at 509-667-7100. <i>You will need to file a s</i>	e receiving treatment at a clinic or hospita le a claim for benefits and obtain an SIF2 self-insured Physicians Initial Report at the	al for the above incident you need form. The Trust can be reached <i>e clinic or hospital.</i>
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