LAKOTA LOCAL SCHOOL DISTRICT

WORKPLACE ACCIDENT REPORT

INSTRUCTIONS: Employees must report ALL work-related accidents or injuries to their immediate supervisor using this form within ONE day of the incident and return completed forms to their supervisor. **Please complete each section of this form in its entirety.** This will help ensure your Worker's Comp Claims will be processed timely. This also supports employees by helping the District identify and correct hazards or issues before they cause additional injuries.

Name:_____ Birth Date_____

Employee ID:_____ Supervisor:_____

Contact Telephone:_____ Building:_____

Job Title:_____ Time Shift Started:_____

Date of Injury_____ Time of Injury:_____

Did anyone see you get hurt? ❑ Yes ❑ No If yes, who?_____

To whom did you report it?_____ Title/Position:_____ When?_____

Location of incident:_____ Did the incident involve a student? ❑ Yes ❑ No

Type of Injury. This section to be completed for all accidents.

❑ Bite ❑ Concussion ❑ Strain/Sprain
❑ Bruise ❑ Cut ❑ Laceration
❑ Burn ❑ Fracture ❑ Other, specify:_____

If bite, was it student related or insect? ❑ Yes ❑ No Did the bite break the skin? ❑ Yes ❑ No

Part of body involved. This must be completed for all accidents.

Left		Right	Left		Right	Left		Right	Left		Right
❑	Chest	❑	❑	Neck	❑	❑	Shoulder	❑	❑	Hip	❑
❑	Back	❑	❑	Teacher	❑	❑	Upper Arm	❑	❑	Upper Leg	❑
❑	Abdomen	❑	❑	Face	❑	❑	Lower Arm	❑	❑	Lower Leg	❑
❑	Groin	❑	❑	Eye	❑	❑	Elbow	❑	❑	Knee	❑
❑	Ear	❑	❑	Nose	❑	❑	Scalp	❑	❑	Toes	❑
❑	Fingers	❑	❑	Ankle	❑	❑	Mouth	❑	❑	Hand	❑

❑ Additional Part of Body (Please Describe):_____

Was any first aid provided at the scene? ❑ Yes ❑ No If yes, describe_____

Will you seek medical treatment from a licensed medical professional? ❑ Yes ❑ No

Did you leave work to seek treatment? ❑ Yes ❑ No What time did you leave work?_____

If no missed work days, did you return to same job? ❑ Yes ❑ No

Describe what caused the injury. If incident involved a student, please do not include their personal information including their name. Please refer to them as student. Be specific:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

What you were doing just before the incident:

_____

_____

_____

What you did after the incident:

_____

_____

_____

I certify that my statements are true and to the best of my knowledge. I hereby authorize any person or persons who will medically treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to disclose such information to my employer, my employer's managed care organization, or to my employer's designated representative, Hunter Consulting. A copy of this form will serve as the original notification of injury.

Employee Signature:_____ Date:_____

ADMINISTRATOR'S APPRAISAL and INVESTIGATION

Please provide witness statements/photos, if applicable.

What actions are being taken to prevent this type of incident from occurring again?_____

_____

_____

Has the employee returned to work? _____

If no, date of expected return: _____

Additional Comments:

_____

_____

_____

Administrator's Signature:_____ Date:_____