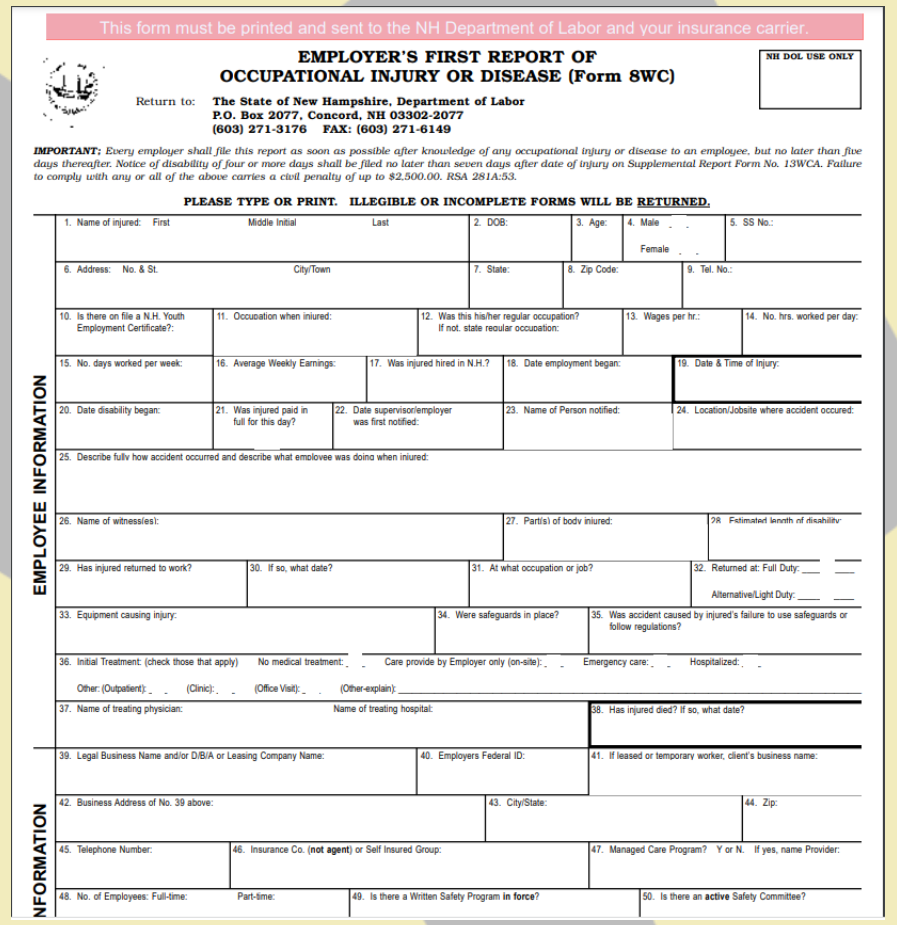
Accidental Workplace Injury | Worker's Comp Process Guide
Lebanon School District SAU #88

Worker's Compensation

- If an employee is involved in any incident that results in an injury of any kind; no matter how small or insignificant it may seem, it must be reported. All employees must fill out an Employee First Report of Occupational Injury Form. When an employee completes an Employee First Report of Occupational Injury Form, the employee must notify the school's principal or assistant principal right away
- Under the law and per the Department of Labor guidelines, the employer must file the report of the accident and form as soon as it happens, but no later than 5 days thereafter. Failure to comply with these requirements can carry a penalty of up to $2,500.00 that can be imposed on the District per RSA 281A:53
- The form is available online at [sau88.net](sau88.net), your principal's office, or at the SAU Building



This form must be printed and sent to the NH Department of Labor and your insurance carrier.

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE (Form 8WC)

NH DOL USE ONLY

Return to: **The State of New Hampshire, Department of Labor**
P.O. Box 2077, Concord, NH 03302-2077
(603) 271-3176 FAX: (603) 271-6149

IMPORTANT: *Every employer shall file this report as soon as possible after knowledge of any occupational injury or disease to an employee, but no later than five days thereafter. Notice of disability of four or more days shall be filed no later than seven days after date of injury on Supplemental Report Form No. 13WCA. Failure to comply with any or all of the above carries a civil penalty of up to $2,500.00. RSA 281A:53.*

PLEASE TYPE OR PRINT. ILLEGIBLE OR INCOMPLETE FORMS WILL BE RETURNED.

EMPLOYEE INFORMATION

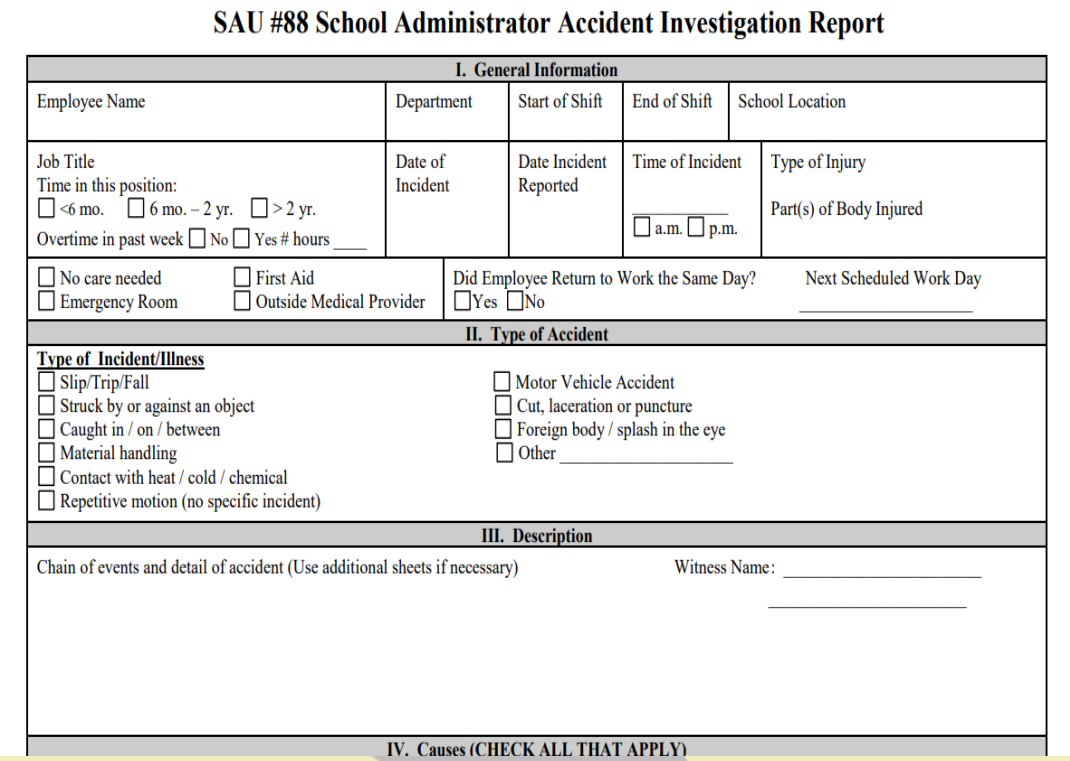
1. Name of injured: First Middle Initial Last | 2. DOB: | 3. Age: | 4. Male Female | 5. SS No.:
6. Address: No. & St. City/Town | 7. State: | 8. Zip Code: | 9. Tel. No.:
10. Is there on file a N.H. Youth Employment Certificate?: | 11. Occupation when iniured: | 12. Was this his/her regular occupation? If not. state reoular occupation: | 13. Wages per hr.: | 14. No. hrs. worked per day:
15. No. days worked per week: | 16. Average Weekly Earnings: | 17. Was injured hired in N.H.? | 18. Date employment began: | 19. Date & Time of Injury:
20. Date disability began: | 21. Was injured paid in full for this day? | 22. Date supervisor/employer was first notified: | 23. Name of Person notified: | 24. Location/Jobsite where accident occured:
25. Describe fully how accident occurred and describe what employee was doing when injured:
26. Name of witness(es): | 27. Part(s) of body injured: | 28. Estimated length of disability:
29. Has injured returned to work? | 30. If so, what date? | 31. At what occupation or job? | 32. Returned at: Full Duty: ___ ___ Alternative/Light Duty: ___ ___
33. Equipment causing injury: | 34. Were safeguards in place? | 35. Was accident caused by injured's failure to use safeguards or follow regulations?
36. Initial Treatment: (check those that apply) No medical treatment: _ _ Care provide by Employer only (on-site): _ _ Emergency care: _ _ Hospitalized: _ _
Other: (Outpatient): _ _ (Clinic): _ _ (Office Visit): _ _ (Other-explain): _____
37. Name of treating physician: Name of treating hospital: | 38. Has injured died? If so, what date?

EMPLOYER INFORMATION

39. Legal Business Name and/or D/B/A or Leasing Company Name: | 40. Employers Federal ID: | 41. If leased or temporary worker, client's business name:
42. Business Address of No. 39 above: | 43. City/State: | 44. Zip:
45. Telephone Number: | 46. Insurance Co. (**not agent**) or Self Insured Group: | 47. Managed Care Program? Y or N. If yes, name Provider:
48. No. of Employees: Full-time: Part-time: | 49. Is there a Written Safety Program **in force**? | 50. Is there an **active** Safety Committee?

Worker's Compensation

- Another important aspect of Worker's Compensation is the investigative side of the process. Having an established investigative procedure can help the employer learn what happened and mitigate the risk of future workplace accidents or injuries from occurring
- In turn, the school administrator that is notified of the employee's accident or injury must then complete the SAU #88 School Administrator Accident Investigation Report. This form is also readily available on [sau88.net](sau88.net)



SAU #88 School Administrator Accident Investigation Report

I. General Information

Employee Name	Department	Start of Shift	End of Shift	School Location

Job Title Time in this position: ☐ <6 mo. ☐ 6 mo. – 2 yr. ☐ > 2 yr. Overtime in past week ☐ No ☐ Yes # hours ____	Date of Incident	Date Incident Reported	Time of Incident _____ ☐ a.m. ☐ p.m.	Type of Injury Part(s) of Body Injured

☐ No care needed ☐ First Aid
☐ Emergency Room ☐ Outside Medical Provider

Did Employee Return to Work the Same Day?
☐ Yes ☐ No

Next Scheduled Work Day
_____

II. Type of Accident

Type of Incident/Illness

☐ Slip/Trip/Fall
☐ Struck by or against an object
☐ Caught in / on / between
☐ Material handling
☐ Contact with heat / cold / chemical
☐ Repetitive motion (no specific incident)
☐ Motor Vehicle Accident
☐ Cut, laceration or puncture
☐ Foreign body / splash in the eye
☐ Other _____

III. Description

Chain of events and detail of accident (Use additional sheets if necessary)

Witness Name: _____
_____

IV. Causes (CHECK ALL THAT APPLY)