



STAFF INCIDENT REPORT FOR WORKERS' COMPENSATION
PLEASE COMPLETE THIS FORM AND SEND TO HUMAN RESOURCES
IMMEDIATELY FOLLOWING THE INCIDENT. PLEASE PRINT.

EMPLOYEE INFORMATION: SSN: _____ Birthdate: _____
Today's Date: _____

First Name _____ Middle _____ Last Name _____

Home Address: _____ City/ST: _____ Zip: _____

Phone: _____ Work Hours: _____ am / pm TO _____ am / pm Meal Break: _____

Position: _____ Bldg: _____ Principal/Supervisor: _____

Did you miss work due to injury? ☐ Yes ☐ No If Yes, Dates & Times: _____

Have you returned to work? ☐ Yes ☐ No ☐ Full / Light Duty If No, Date Expected to Return: _____

DATE OF INCIDENT: _____ **TIME:** _____ am / pm **DATE REPORTED:** _____

Where Injury Occurred-Building: _____ **Location:** _____

Witness(es) to Incident: _____ **Injury Reported to:** _____

EXPLAIN IN DETAIL how injury occurred: _____

TYPE OF INJURY:		BODY PART(S) AFFECTED:	
Abrasion _____	Head Injury _____	Abdomen _____	Eye* _____
Bruise/Bump _____	Fracture _____	Ankle* _____	Face _____
Burn _____	Laceration _____	Arm* _____	Finger _____
Cut _____	Puncture _____	Back _____	Foot* _____
Convulsion _____	Shock _____	Chest _____	Hand* _____
Discoloration _____	Sprain _____	Elbow* _____	Other: _____
Other: _____		<i>* Specify Left, Right or Both</i>	

Was blood or other body fluid involved in the Incident? _____ Yes _____ No
IF YES, COMPLETE THE REVERSE SIDE OF THIS FORM "BLOOD/BODY FLUID EXPOSURE INCIDENT REPORT."

TREATMENT: Did you seek treatment? ☐ Yes ☐ No If Yes, Dates & Times: _____

Dr.'s Name: _____ Return Visit Date: _____

What type of treatment are you getting? _____ How are you getting along? _____

Have you ever injured this part of your body before? _____ Yes _____ No If Yes, explain when, how, and to what extent: _____

REQUIRED SIGNATURES:

Employee Signature: _____ Date: _____

Supervisor/Principal Signature: _____ Date: _____

SEND COMPLETED REPORT TO HUMAN RESOURCES AT CENTRAL OFFICE

OVER

BLOOD / BODY FLUID EXPOSURE INCIDENT REPORT

PLEASE COMPLETE THIS SECTION ONLY IF BLOOD OR BODY FLUIDS WERE INVOLVED IN THE INCIDENT.

PLEASE PRINT (This information is for District Information / Statistics only.)

Date of Exposure: _____

Time of Exposure: _____ am / pm

Employee Name: _____ Position: _____ Bldg: _____

Exposure Incident (Describe what happened): _____

Route of Exposure (Bite, needle stick, etc.): _____

Source Individual: _____

Witness(es): _____

Was incident reported to School Nurse? Yes ____ No ____ Follow-Up: _____

Employee Signature: _____ Date: _____

Supervisor/Principal Signature: _____ Date: _____

WORKERS COMP REQUIRES EMPLOYEES TO COMPLETE THIS SECTION AFTER EVERY INJURY**EMPLOYEE'S CHOICE OR CHANGE OF DOCTOR FORM**

A: RIGHTS OF THE EMPLOYEE Under the Nebraska workers' compensation laws, you may have the right to choose a doctor to treat you for your work-related injury. You may choose a doctor who has treated you or an immediate family member before this injury happened. Immediate family members are: your spouse, children, parents, stepchildren and stepparents. The doctor you choose must have records to show that past treatment was provided. Your employer may ask the person who was treated to give permission so the doctor can verify past treatment.

If you want to choose your doctor, you must tell your employer the name of the doctor you choose. Do this as soon as possible after your employer gives you this notice and before getting treatment unless it is emergency medical treatment. Once you tell your employer the name of the doctor, you may not change your choice unless your employer agrees or the Nebraska Workers' Compensation Court orders a change.

If you do not choose your doctor, your employer has the right to choose the doctor to treat you. The employer may also choose the doctor to treat you if you or your family member does not give permission so your employer can verify past treatment by the doctor you chose. You may choose a doctor if your claim is denied. You may also choose the doctor to do major surgery or for an amputation. You may use Part B below to tell your employer the name of the doctor you choose.

B: CHOICE OF DOCTOR

- ☐ I choose the following doctor to treat me for this work-related injury. I certify that this doctor has treated me or an immediate family member before the work-related injury.
- ☐ I do not have or I do not wish to choose a doctor who has treated me or an immediate family member.

Doctor's Name

Signature of Employee

Doctor's Address

Date

C: USE TO CHANGE THE CHOICE MADE IN PART B ABOVE I wish to change my choice of doctor or I wish to choose a doctor to treat me for my work-related injury. I certify the doctor named below has treated me or an immediate family member before this work-related injury. I understand that I cannot make this change unless my employer agrees or unless the Nebraska Workers' Compensation Court orders a change.

Doctor's Name

Signature of Employee

Date

Doctor's Address

Signature of Employer

Date

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NWCC Form 50 (Rev 1/97); Required by KPS Worker's Comp Carrier Sedgwick Claims Mgmt, Inc Omaha, NE; Effective 1/04

SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

NOTICE TO EMPLOYER: GIVE THIS FORM TO THE SUPERVISOR OF THE INJURED WORKER TO COMPLETE AND RETURN TO HUMAN RESOURCES IMMEDIATELY AFTER EVERY INJURY.

Building _____ Date _____ Time of Accident _____

Employee _____ Nature of Injury/Illness _____

ACCIDENT FACTORS

What happened? _____

ACCIDENT TYPE

(Check one)

☐ Fall-Same Level	☐ Struck By	☐ Lifting, Moving	☐ Cut/Puncture	☐ Other _____
☐ Fall-Different Level	☐ Struck Against	☐ Pushing/Pulling	☐ Burned	
☐ Caught In, On, Between	☐ Over Exerted	☐ Twisted	☐ Trip/Slip	

ACCIDENT CAUSES

What specific act was responsible for this accident? _____

What specific condition was responsible for this accident? _____

Reasons why the unsafe act was committed and/or why did the unsafe condition existed?

☐ Lack of Knowledge/Experience	☐ Defective Equipment
☐ Adverse Weather	☐ Failure to use proper Personal Protection Equipment
☐ Improper Lifting/Carry	☐ Housekeeping Conditions ☐ Other _____

CORRECTIVE ACTION

What do you suggest to prevent any similar accidents?

☐ Instructional Training ☐ Repair ☐ Eliminate ☐ Motivation ☐ Proper Placement

Other comments: _____

Signature of Principal/Supervisor _____ Date _____

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