Erie's Public Schools Employee Incident Report

Fax completed report and workers compensation acknowledgment to Human Resource Department at 814.874.6083.

To be completed by employee only.

Today's Date:___/____/___ Date of Injury: ____/_____/____ Social Security # _____/_____/_____

Employee Name: _____Phone: _____
(First) (Middle) (Last)

Home Address: _____ City: _____State:____ Zip:_____

Male ☐ Female ☐ # of Dependents under 18: _____ Married Y N Date of Birth: ____/_____/____

Job Title: _____ School/Department: _____

Time Started Work:_____ ☐am ☐pm Time of Incident: ____:____ ☐am ☐pm

Location of Incident: _____
(Physical Address) (Area of worksite)

In your words, describe fully how the incident happened, including what specific activity you were doing just before and when the incident took place, as well as the chain of events leading up to the incident:

Include words such as pushing, pulling, climbing, etc. ….. note any objects, equipment, or tools involved……note special characteristics in the work environment contributing to the incident.

_____

_____

_____

Was there property damage? ☐Yes ☐No If yes, what property/equipment was damaged? _____

_____ Property/equipment owned by: _____

Describe the damage: _____

Describe what part of your body is injured/ hurt and in what way: OR ☐ No injury

Examples: Sharp pain in right shoulder, bruised left knee, throbbing pain in left calf, etc……

_____

_____

****Please also indicate these areas of injury on the diagram on page 2****

Can you think of anything you could have done differently or how possibly we can prevent this incident from happening again?

_____

_____

Were you working where other co-workers were nearby or present when the incident happened? ☐ Yes ☐ No

If so, who: _____

Name(s) of Witness(es) who may have seen/heard the incident: 1. _____ 2. _____
(First) (Last) (First) (Last)

Who did you report this incident to? _____
(First) (Last)

Name of your supervisor: _____
(First) (Last)

When did you first report this incident to your supervisor? Date: ____/____/____ Time: ____:____ ☐am ☐pm

Do you require medical attention?

☐ **N/A,** no injury

☐ **Yes**

We ask that you turn in any documentation received from the healthcare provider regarding your visit, to include any medication prescribed, return to work status, and diagnosis so that the Personnel Office may ensure timely processing.

☐ **No** (if no is checked, please complete medical waiver below):

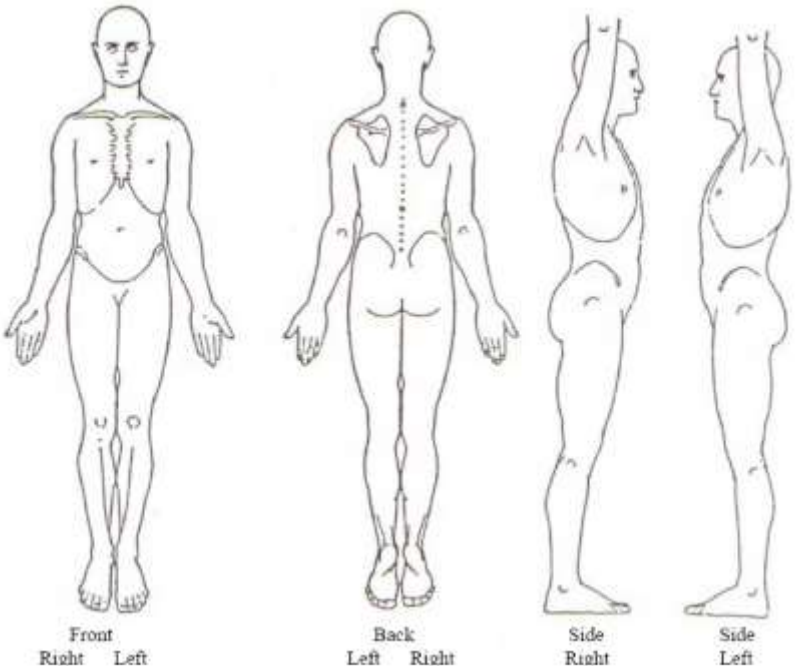
I hereby acknowledge that my supervisor(s) has offered and made available to me an opportunity to seek necessary medical treatment and/or observation at the expense of my employer, Erie's Public Schools, for the work-related injury I incurred on this date. I am voluntarily choosing to decline medical treatment and/or observation at this time.

I understand that I may request from my employer, at a later time, authorization to obtain medical treatment and/or observation for the injury described above. However, I understand that my refusal of medical treatment and/or observation today may impact my eligibility for workers' compensation benefits related to the injury described above.

_____ _____

Employee Signature Date

Directions: On the body diagram below, please mark with a dot (●) the area(s) of your body you feel has been injured as a result of this incident.



I certify that these are true and accurate statements of my incident/injury that occurred on __/____/____.

Signature of Employee: _____ Date: _____

Supervisor: (print name): _____ Job Title: _____

Signature: _____ Date: __/____/____ Time: ____:____ ☐am ☐pm rev.7/2017