MECHANICVILLE CITY SCHOOL DISTRICT INCIDENT REPORT

Reported by *(Name, Title, Phone)*_______________________________________ Date Reported ________________

Injured Party Information:

Injured Party Name ____________________________________ Sex: M ☐ F ☐ D.O.B. ______________

Address ____

E-mail Address ________________________________ Home Phone # _____________Cell Phone # ___________

Full Time Employee ☐ Part Time Employee ☐ Substitute Employee ☐ Visitor ☐

Days Worked ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ SA ☐ SU 10 mo emp ☐ 11 mo emp ☐ 12 mo emp ☐

SS # ________________________ Date of Hire ____________ Wages/Hour ___________________________

Job Title/Occupation ______________________________ How Long Employed at MCSD?__________________

Job Worksite (*e.g. School/Building*)____

Incident Date __________________ **Case number on *Log***: __________

Time of Day Employee Began Work _____________ **AM / PM** **Time Event Occurred** _____________ **AM / PM**

Event occurred ☐ before ☐ during ☐ after work shift Check if time cannot be determined. ☐

Location of Incident (Building and Building area) _______________________________

What activity was being done just before incident occurred? *Describe the activity, as well as the tools, equipment, or material used. Be specific. Examples: "climbing a ladder while carrying roofing materials", "spraying chlorine from a hand sprayer."*

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What happened? *Describe how the injury occurred? Examples: "When ladder slipped on wet floor, worker fell 20 ft.", "Worker was sprayed with chlorine when gasket broke during replacement.*

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What was the injury or illness? *Describe the part of the body affected; be more specific than "hurt", "pain", or "sore." Examples: "strained lower back", "chemical burn, left hand".* ____

What object or substance directly harmed the employee: *Examples: "concrete floor", "radial arm saw", "chlorine."*____

Any Property, Product, or Equipment Damage Yes ☐ No ☐ **Motor Vehicle Accident?** Yes ☐ No ☐

If Yes, Describe ____ ___________________________

<u>MUST PROVIDE DOCTOR'S EXCUSE FOR ANY MEDICAL TREATMENT, RESTRICTED WORK OR LOST TIME</u>

How serious was the injury? (Circle One, A- E) ***Please see instructions for definition of medical treatment, restricted work and lost time.***

A. Did not require treatment more than First Aid.
B. Required treatment more than First Aid, but did not result in lost time. (See Above)
C. Resulted in lost time. (See Above)
D. Restricted activity. (See Above)
E. Resulted in death. Date of Death ____/____/____

Were there Witnesses? Yes ☐ No ☐ If yes, who: ____

Has issue been Corrected? Yes ☐ No ☐ If Yes, How:____

If No, Why not? ____

What steps have been taken to prevent similar incidents?_____________________________________

What steps should be taken to prevent a recurrence?____

Did Nurse Provide Care onsite? Yes ☐ No ☐ If yes, Who? _________________________ Treatment? ___________________________

Additional Medical Care sought? Yes ☐ No ☐ If yes: Provider Name__________________________ When?___________________

Doctor ____ Hospital ____

Was employee treated in an emergency room? Yes ☐ No ☐ Was the employee hospitalized overnight? Yes ☐ No ☐

An employer or carrier, or any employee, agent, or person acting on behalf of an employer or carrier, who KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under Workers Compensation for the purpose of avoiding provision of such payment or benefit SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

(EMPLOYEE) By signing this form, I certify the information is true and accurate.

Employee Name (print)	**Signature**	**Date**
Supervisor Name (print)	**Signature**	**Date**
Nurse Name (print)	**Signature**	**Date**

OFFICE USE ONLY:

Employee Name: ____________________________________ Date of Incident _______________ Case number on *Log*: __________

Ongoing treatment for Accident? Yes ☐ No ☐

Date Stopped Work Due to Accident ________________

Employee Paid for Full Day on Day of Accident? Yes ☐ No ☐

Salary Continuation? Yes ☐ No ☐

Date Returned to Work (RTW) ____________________

RTW Full Duty? ☐ RTW Restricted Duty? ☐

Medical Excuse/Treatment Documentation Received for Injuries/Illnesses requiring treatment beyond First Aid? Yes ☐ No ☐

☐ **ILLNESS CASES ONLY:** Check this box if the employee independently and voluntarily requests that his or her name not be entered on the log. If checked, treat as a privacy concern case.

MECHANICVILLE CITY SCHOOL DISTRICT **REPORTING WORK-RELATED INJURIES AND ILLNESSES**

An injured employee must complete an Incident Report for work-related injuries and illnesses. The information provided below will enable both the school and district to learn about what contributed to the incident and discover potential system failures so they can be corrected. If possible, this form should be completed and submitted to your supervisor within 24 hours of injury or illness.

Employees: If you have a work-related injury, you are required to follow these steps:

1. Immediately report the injury to your supervisor and go see the school nurse, so that you can be checked out.

2. Complete an Incident Report form (located in _____________). Please make sure to fill out the entire form and print clearly. Your signature is mandatory and **all applicable information must be completed**.

3. The nurse and your supervisor are required to sign the Accident/Investigation Report form.

4. The original Incident Report form must then be sent over to Debra Robert, Human Resources, within 3 days for processing and sending on to PMA Group, the District's Workers' Compensation administrator.

5. MUST PROVIDE DOCTOR'S EXCUSE FOR ANY MEDICAL TREATMENT, RESTRICTED WORK OR LOST TIME. Send to Debra Robert, Human Resources.

Supervisor responsibilities: Supervisors must submit a completed copy of this form to Human Resources within 3 days of incident. Also ensure the employee is provided with a copy of the completed form.

This form must be used to document on-the-job-injuries requiring treatment beyond first aid, lost time and restricted work. Should you need to seek outside medical treatment, beyond first aid:

Medical Treatment Beyond First Aid means the management and care of a patient to combat a disease or disorder such as treatment of pain or infection with prescription medication, stitches, casts, chiropractic manipulation, physical therapy, oxygen administered for symptoms upon inhalation exposure, or upon loss of consciousness resulting from a workplace event/exposure. Medical treatment does not include 1) visits to a physician or other licensed health care professional solely for observation or counseling, 2) the conduct of diagnostic procedures, such as x-rays and blood tests, including the administration of prescription medications used solely for diagnostic purposes (e.g., eye drops to dilate pupils).

Lost Time: Days away that a physician or other licensed health care professional recommends to the employee. The days away must be recorded.

Restricted Work: When 1) the employer keeps an employee from performing one or more of the routine functions of his or her job, or from working the full workday that he or she would otherwise have been scheduled to work; or 2) a physician or other licensed health care professional recommends that the employee not perform one or more of the routine functions of his or her job, or not work the full workday that he or she would otherwise have been scheduled to work.

1. Let your doctor know that your injury happened at work, and tell your doctor to file reports with the Workers' Compensation Board and with PMA Group. Do not pay for any doctor or hospital bills – PMA will do that for you.

2. Tell your doctor to schedule diagnostic services (X-Rays, MRI, CT Scan, EMG/nerve conduction studies and other diagnostic testing) through PMA's network. Your doctor can schedule services by calling ____________________, or fax the referral to __________________, or email them at ___________________.

3. Fill any prescriptions through PMA's pharmacy network_________________ You are required by Workers' Compensation Law to use PMA's prescription network. If you choose not fill your prescription through PMA's pharmacy network, your prescriptions may not be paid under this Plan.

Questions? Call PMA representative
PMA representative contact info:

The information provided on this form may be used to record and report work-related fatalities, injuries and illnesses on the DOSH 900 Log, DOSH 900.1 Annual Summary Report and to meet the requirements of the DOSH 900.2 Injury and Illness Report.