Incident Report

The top portion of this report is to be completed by the employee/volunteer/visitor at the time of the incident. The bottom portion is to be completed the on-duty supervisor or building administrator on the same day as the accident. Please return this form to your Supervisor immediately following the incident.

Filing an Incident Report does not constitute a Workers' Compensation claim. Injured employees/volunteers/visitors who go to the doctor after an Incident Report and Pain Diagram is filed must immediately notify the district that they required medical treatment beyond first aid. If you seek medical treatment, you will need to fill out the 801 form from the District Office. Please return all paperwork to the District Office as soon as possible.

Employee/Volunteer/Visitor

Name of Employee/Volunteer/Visitor: ______________________ Gender: ○ Male ○ Female

Job Title: ______________________

District ______________________ Department: ______________________

Work Shift: ______________________

Date of Incident: ______________________ Time of Incident: ______________ ○ am ○ pm

Incident Location: ______________________

Reported to: ______________________ Phone: ______________________ Staff: ○ Yes ○ No

Witness: ______________________ Phone: ______________________ Staff: ○ Yes ○ No

Witness: ______________________ Phone: ______________________ Staff: ○ Yes ○ No

First Aid Given? ○ Yes ○ No

If yes, please indicate the type of first aid: ☐ Ice ☐ Washed Wound ☐ Kept Immobile ☐ Stopped Bleeding ☐ Observed ☐ Applied Splint ☐ Applied Dressing ☐ Other: __________

Do you require medical treatment beyond first aid? ○ Yes ○ No
If yes, you must complete form 801 in addition to the Incident Report and Pain Diagram.

Body Part(s) Injured: Indicate your injuries below. **Also complete attached Pain Diagram.**

HEAD	TRUNK	EXTREMITIES		OTHER
☐ Ear	☐ Abdomen	☐ Ankle	☐ Lower Arm	☐ __________
☐ Eye	☐ Back	☐ Elbow	☐ Lower Leg	☐ __________
☐ Face	☐ Chest	☐ Finger	☐ Thumb	☐ __________
☐ Head	☐ Groin	☐ Foot	☐ Toes	☐ __________
☐ Neck	☐ Shoulder	☐ Hand	☐ Upper Arm	☐ __________
☐ Scalp	☐ Trunk	☐ Knee	☐ Wrist	☐ __________

SUSPECTED NATURE OF INJURY: ☐ Bruise/Contusion ☐ Sprain/Strain ☐ Laceration/Abrasion ☐ Fracture ☐ Concussion ☐ Dislocation ☐ Burn ☐ Surface Cut/Scratch ☐ Other: ______________

SUSPECTED CAUSE OF INJURY: ☐ Fall/Slip ☐ Push/Pull ☐ Lifting ☐ Other: ______________

Describe how incident occurred, including events that occurred immediately before the accident: *(Field limited to 3 lines of text.)*

I certify, as attested by my signature below, that all information I have given is true and contains no false statements and/or misrepresentations.

Print Employee/Volunteer Name: ______________________

Employee Signature: ______________________ Date: ______________

Supervisor

Date Reported: ______________ Time: ______________ ○ am ○ pm To Whom? ______________

Were other workers injured? ○ Yes ○ No *If yes, please name:* ______________________

Additional Comments: *(Field limited to 2 lines of text.)*

I certify, as attested by my signature below, that all information I have given is true based on my knowledge of the incident.

Print Supervisor Name: ______________________

Supervisor Signature: ______________________ Date: ______________

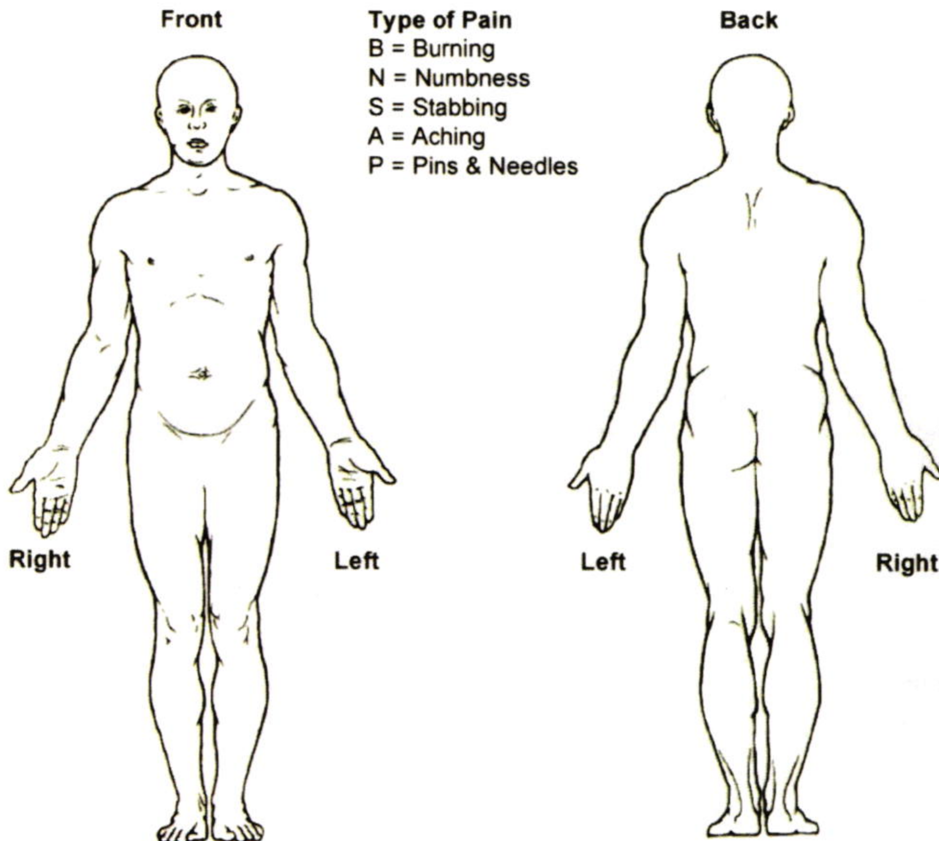
Pain Diagram

Please complete the Pain Diagram and submit along with the completed **Incident Report** or **Form 801**, or both. Retain a copy for your records and return all originals to the District Office.

Please Note: Completion of the Pain Diagram is voluntary and is not required to apply for workers' compensation benefits.

Name: ______________________ Employer: ______________________

Please mark the area of injury or discomfort on the chart below using the appropriate symbols:



Pain Scale

0 = No Pain *10 = Severe Pain*

Check one: ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Please use the space below to describe your condition further, if needed:

I certify, as attested by my signature below, that all information I have given is true and contains no false statements and/or misrepresentations.

Print Worker's Name: ______________________

Worker's Signature: ______________________ Date: ______________________

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