Employee Incident, Workplace Violence, and Illness Report

This Page Must Be Completed By Employee

Case No.

Date of Incident

mm/dd/year

TO BE COMPLETED BY EMPLOYEE

Social Security # (Last 4)	Name (Last) (First) (MI)	Sex (M or F)	Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Home Address	City	State	Zip	Home #	Work #

Date of Birth	Age	Occupation	Department	Work Location and Title

Work Status: ☐ Full time ☐ Part time	Hours per Day	# Days per week if part time	Immediate Supervisor

Injured body part areas *(indicate left or right if applicable)*	District building where incident occurred *(street, city, zip code)* *Exact Location:*

Time of Day incident occurred: AM or PM	Date employer was advised: mm/dd/year

Is this a recurrence of a previous incident, injury or illness? ☐ Yes ☐ No
If "YES" please give details:

Employee's Statement

Please describe in detail how the incident occurred. Include what led up to the incident, any persons, objects or tools involved, and how it ended. How did the accident occur? *(Explain how it happened)*

Is this an incident of Workplace Violence? ☐ Yes ☐ No

Was or will medical care be provided by school nurse? ☐ Yes ☐ No If yes, please complete the following below:

Was or will medical care be provided other than by school nurse? ☐ Yes ☐ No If yes, please complete the following below:

School Nurse's Name	*Doctor's Name*	*Emergency Room Location*
School	*Doctor's Address*	*Hospital*

Were there any witnesses to the accident? ☐ Yes ☐ No If yes, please complete the following:

Witness Name: Was the witness a District employee? ☐ Yes ☐ No Witness Phone#:

Witness Name: Was the witness a District employee? ☐ Yes ☐ No Witness Phone#:

If witness is not a District employee, please provide name and address:

Employee Signature *Date*

"Any person who knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, self-insurer or purported insurer, or any agent thereof, any written statement as part of or in support of a claim for benefits containing any false, incomplete, or misleading information commits a fraudulent insurance act."

2/2024 RME

Employee Incident, Workplace Violence, and Illness Investigation Report

*This Page Must Be Completed By **Employer/Supervisor***

Employee Name: **Date of Incident:**

Supervisor's Investigation / Report: *This section must be completed by the supervisor prior to signing.*

TO BE COMPLETED BY SUPERVISOR

1. Cause Analysis: *Describe the factors contributing to this incident.*

2. Work Status: *Is the employee missing time from work:* ☐ Yes ☐ No ☐ Don't Know

If Yes, how much time has employee missed?

What date is employee expected to return?

3. Recommended Corrective Actions: *What actions can I will be taken to prevent recurrence of this incident?*

_____
Supervisor's Signature *Date*

Instructions

- *Page 1 of this report must be completed and signed by the employee.*
- *Page 2 of this report must be completed by the employee's immediate supervisor.*
- *The original completed form must be sent to the Lead Secretary/Building Designee upon*
- *completion. Once reviewed for accuracy, this form is to be forwarded to Human Resources.*
- *The supervisor is to follow up on the recommended corrective actions to prevent a recurrence.*

PRIVACY NOTE: If the case is a "privacy concern case", remove the name of the employee who was the victim of the incident and enter "PRIVACY CONCERN CASE" in the space normally used for the employee's name. Privacy concern cases typically involve injury or illness to an intimate body part or reproductive system, incidents resulting from sexual assault, mental illness, HIV infection, needle stick injuries and cuts from sharp objects that may be contaminated with another person's blood or other potentially infectious material, and other illnesses if the employee independently and voluntarily requests that his or her name not be entered on the report.