

# EMPLOYEE ACCIDENT REPORT

**Part 1: To be completed by employee. Fill in all of the blanks.**

Employee's full name \_\_\_\_\_ Social Security# \_\_\_\_\_ DOB \_\_\_\_\_ Sex \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home # \_\_\_\_\_ Work # \_\_\_\_\_ Job title \_\_\_\_\_  
 Location (school, building & area where incident occurred) \_\_\_\_\_  
 Date of injury \_\_\_\_\_ Time of injury \_\_\_\_\_ a.m./p.m. Scheduled shift: from \_\_\_\_\_ to \_\_\_\_\_  
 Last date worked \_\_\_\_\_ Return to work date \_\_\_\_\_ Days missed due to injury \_\_\_\_\_  
 Describe what happened in detail (What you were doing? lifting/pushing/pulling, indoors/outdoors, using tools/machinery, chemicals/ fumes)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Body part(s) injured \_\_\_\_\_ Right / Left

Witnesses to actual incident \_\_\_\_\_

Date reported to supervisor as work related \_\_\_\_\_ Reported to \_\_\_\_\_ Title \_\_\_\_\_

First aid only? **Yes / No** Seen by a doctor? **Yes / No** If yes, provide doctor's name, clinic or hospital name, address, city, state, zip, telephone number and date examined below.

\_\_\_\_\_

**La Center School District is a self-insured member of the Southwest Washington Workers' Compensation Trust (the Trust). If you have or will be receiving treatment at a clinic or hospital for the above incident you need to contact the Trust at Educational Service District 112 to file a claim for benefits and obtain an SIF2 form. The Trust can be reached at 1-800-749-5861 or 360-750-7504. You will need to file a self-insured Physicians Initial Report at the clinic or hospital.**

Employee signature \_\_\_\_\_ Date \_\_\_\_\_

**Part 2: To be completed by supervisor. Fill in all of the blanks.**

Date of injury \_\_\_\_\_ Date incident reported to you as work related \_\_\_\_\_  
 If not reported the same day why? \_\_\_\_\_  
 Date incident investigated \_\_\_\_\_ If equipment/tool damaged describe \_\_\_\_\_  
 Employee job title \_\_\_\_\_ Employee date of hire \_\_\_\_\_  
 Shift on date of injury \_\_\_\_\_ Time employee left work on date of injury \_\_\_\_\_  
 Last date worked \_\_\_\_\_ Return to work date \_\_\_\_\_ Days missed due to injury \_\_\_\_\_  
 Describe incident, specify body part(s) injured \_\_\_\_\_  
 Why did the incident occur? \_\_\_\_\_  
 What steps were taken to prevent similar incidents? \_\_\_\_\_  
 Was incident caused by anyone not on school district payroll? If yes give name, address, and attach a copy of any police reports or in-house school district reports filed. \_\_\_\_\_  
 Comments \_\_\_\_\_

\_\_\_\_\_

Supervisor signature \_\_\_\_\_ Date \_\_\_\_\_

Supervisor printed name, title & telephone # \_\_\_\_\_

**Part 3: To be completed by district office. Fill in all of the blanks.**

Hours worked each day \_\_\_\_\_ Days worked per year \_\_\_\_\_ Hourly wage at time of injury \_\_\_\_\_

District office signature \_\_\_\_\_ Date \_\_\_\_\_