LAKE CHELAN SCHOOL DISTRICT NO. 129
EMPLOYEE INCIDENT REPORT

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

Employee's full name ______________________________ 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 ______________
Severity of Incident: No injury/Near miss incident: **Yes / No** 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:

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Describe what happened in detail (What you were doing? lifting/pushing/pulling, indoors/outdoors, using tools/machinery, chemicals/ fumes)

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Body part(s) injured ____ Right / Left

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Witnesses to actual incident ____
Date reported to supervisor as work related ______________ Reported to ______________ Title ______________

Your employer/school district is a self-insured member of the North Central 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 NCESD 171 to file a claim for benefits and obtain an SIF2 form. The Trust can be reached at 509-667-7100. ***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 ____

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Supervisor signature ______________________________________ **Date** ____________________
Supervisor printed name, title & telephone # ____

Send Completed Report to the District Office

Original Copy – Kept in District Office

If the Employee Seeks Medical Care - Fax or Email a Copy to the NCW WC Trust at the NCESD

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