North Coast Schools
Insurance Group

District Occupational Accident Report

Employee Name: _____ **Job Title:** _____
Supervisor Name: _____ **School Site:** _____
Time work began: _____ **Regular Schedule:** _____

Important: Failure to report occupational injuries in a timely manner and/or failure to comply with the District's policies for medical treatment of occupational injuries could result in delay of any possible workers' compensation claim benefits. Workers' compensation claims may be subject to investigation by the insurance carrier. The employee must be treated by the District's designated medical facility if a physician was not previously pre-designated. ***Any person who makes or causes to be made any knowingly false or fraudulent material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.***

INCIDENT INFORMATION

Does this injury require immediate medical attention? ☐ Yes ☐ No

Date of Incident: _____ Date Reported: _____ Time of Incident: _____

Who was incident reported to? _____

Were you performing your regular job duties at the time of accident? ☐ Yes ☐ No

If No, please explain: _____

Location where incident occurred: _____

Were there any witnesses to the accident? ☐ Yes ☐ No

If yes, please list witness names: _____

Were there any safety hazards, if yes explain: ☐ Yes ☐ No

How did the incident happen? Describe specific activity being performed, including tools, equipment, or materials used:

Describe body part(s) affected & how the body part is affected (i.e. bruising, sprain, etc.):

Any previous injuries to affected body part(s)? ☐ Yes ☐ No

If yes, please explain: _____

Any previous workers compensation claims: ☐ Yes ☐ No Details: _____

Additional Concerns (attach additional page if necessary): _____

What corrective or preventive actions will be implemented to avoid a recurrence of this incident?

Employee Signature *Reviewer Signature*