



Employee Incident Report **STAFF**

CONFIDENTIAL

Instructions: Have the employee complete pages 2-5 and email to Dawn Fox and copy Rick Towell. A supervisor will complete pages 6-11 and return to the Risk Manager and copy Dawn Fox.

***** PLEASE READ *****

Employee **MUST** report to the Safety Department with "**Return to Work**" note from the doctor **before** reporting back to their regular job.

Employee's Report of Injury Form

Instructions: Employees shall use this form to report all work related injuries, incidents, or "near miss" events (which could have caused an injury or illness) - *no matter how minor*. This helps us to identify and correct hazards before they cause serious injuries. This form shall be completed by employees as soon as possible and given to a supervisor for further action. **Please print or type only.**

* **This form MUST be completed by the injured employee.** The only exception is if the injured employee is incapacitated.

Do you plan to seek medical attention? <input type="checkbox"/> Yes <input type="checkbox"/> No		**Prior authorization/insurance forms required before visiting clinic.	
I am reporting a work related: <input type="checkbox"/> Injury <input type="checkbox"/> Incident <input type="checkbox"/> Near miss			
Your Name:			
Job Title:			
Supervisor:			
Have you told your supervisor about this injury/near miss? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Date of injury/near miss:		Time of injury/near miss:	
Name of witnesses (if any):			
Where, exactly, did it happen?			
What were you doing at the time?			
Describe step-by-step what led up to the injury/near miss (continue on the back if necessary):			
What could have been done to prevent this injury/near miss?			
What parts of your body were injured? If a near miss, how could you have been hurt?			

If medical treatment is necessary, you must seek treatment at:

**PROMED MINOR EMERGENCY CLINIC, 812 WEST INNES STREET, SALISBURY, or
AFTER HOURS, NOVANT HEALTH ROWAN MEDICAL CENTER EMERGENCY ROOM.**

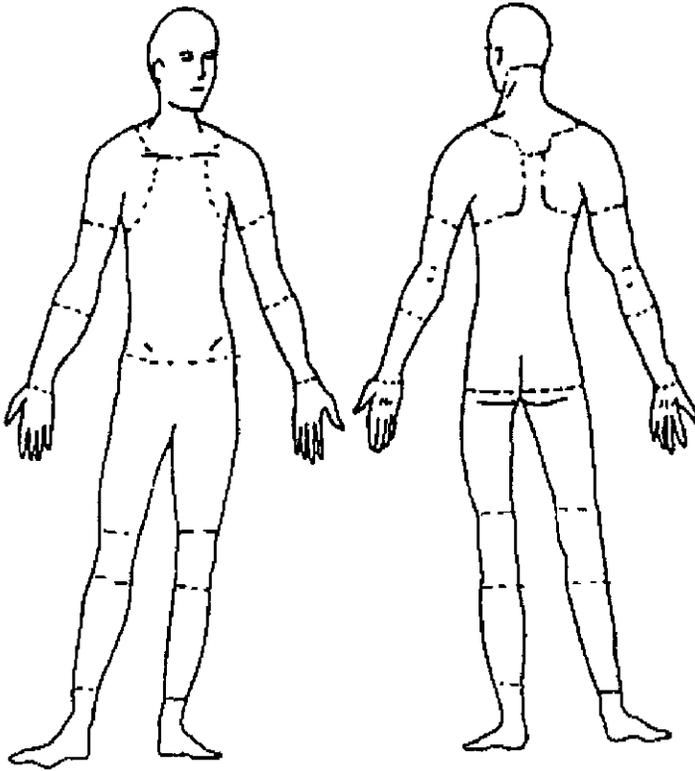
** You **may not change** doctors unless the last treating physician refers you to another doctor, which must be approved through the Workers' Compensation Office. You **may not go** to your family physician**

Has this part of your body been injured before? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, when?	
Do you have other employment? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, company name:	

The information in this report is true and correct to the best of my knowledge. I understand any false statement on this report or any reports related to my incident, will result in disciplinary action up to and including dismissal.

Signature: _____ Date: _____

Indicate the part of your body injured on the diagram below.



Rowan-Salisbury School System Workers' Compensation Injury / Incident Report (circle one)

Today's Date: _____

Employee's Name (first, middle initial, last)

Social Security Number (last 6 numbers)

Address

City

State

Zip Code

Home Phone Number

Cell Phone Number

Job Title

Date of Injury/Incident

Time of Injury/Incident AM or PM

Date of Birth

Start Time

Stop Time Total

Hours worked per Day

Shoe Type

School or Department

Waiting Period – No compensation shall be paid for the first seven days of disability unless the disability continues for more than 21 days. (Sick leave may be used for the first seven days) (NC Industrial Commission Rule) **NO EXCEPTIONS.**

Use of Leave – If you lose time from work, you may choose one of the following:

- Elect to take sick leave during the required waiting period and then go on Workers' Compensation leave and begin drawing Workers' Compensation weekly benefits. (NC Industrial Commission Rule).
- Elect to go on Workers' Compensation leave with no pay for the required waiting period and then begin drawing Workers' Compensation weekly benefits (NC Industrial Commission Rule).

Workers' Compensation Rate – sixty-six and two thirds of your average weekly wage during the 52 weeks prior to the date of the injury not to exceed the maximum established by the NC Industrial Commission.

Nursing Services -Nursing services are provided only at the request of the treating physician. NOTE: Housekeeping services in your home and/or childcare are not considered nursing care.

Prescription Drugs –All prescription drugs are to be filled at **Walgreens/Wal-Mart** according to the proper authorization form. Any reimbursement must be filed on a Form 25P with attached receipts. Request from Safety Department.

Travel – Employees are entitled to mileage for medical treatment at the yearly rate beyond a 20-mile radius (round trip) from the point of origin. FORM25T must be completed for reimbursement. Request from Safety Department.

"THE ACT OF EMPLOYEES FILING A FRAUDULANT CLAIM COULD BECOME GROUNDS FOR DISCIPLINARY ACTION INCLUDING TERMINATION. THIS INCLUDES CHANGING SHOES AFTER HAVING AN INJURY."

I have read the above outlined information and understand the rules set out to be followed in the handling of my claim.

Signature of Employee: _____

Date: _____

Witness of Employee's Signature (Site Representative): _____ Date: _____

Medical Authorization

The undersigned person(s) hereby consents to, and by the Authorization or any photocopy hereof authorizes, the release to Rowan Salisbury Schools or any other agent or employee of Rowan Salisbury School by any hospital, medical clinic, surgeon, physician, pharmacist or any other provider of medical services, treatment or supplies to

(Name of Patient, Claimant)

Of any and all medical report, histories, findings, prognosis, diagnosis, bills, information or other documents relating to any medical treatment, hospitalization, prescription drugs or other medical services or supplies, including but not limited to psychiatric treatment, or treatment for alcoholism or drug abuse, of such patient for the last 10 years. Please list all physicians/hospital for the past 10 years.

The undersigned person(s) understands and hereby acknowledges that the information above or certain portions thereof, may be protected from disclosure without this signed Authorization by Federal and State privacy and confidentiality laws.

The Authorization shall automatically expire without express revocation one year after signature date below.

And prior to such time shall be subject to revocation with respect to all or any particular records at any time by the undersigned person(s) in writing delivered to the holder of such records except to the extent that action has already been taken in reliance upon this Authorization.

Date: _____

Claimant: _____
(Print Name)

Claimant: _____
(Signature)

Date: _____

Witness: _____
(Print Name)

Witness: _____
(Signature)

Supervisor Incident Investigation Report

STAFF
CONFIDENTIAL

COVER SHEET CHECKOFF

- Supervisor's Report
- Witness Statements
- # of Statements _____
- Names of Witnesses
- Photos of location showing cause/conditions

This is a **Supervisor Incident Investigative Report**. This report is a confidential report of the Rowan Salisbury Schools System. This report shall **NOT** be released by any RSS employee, except for the Workers' Compensation Administrator or the Risk Manager for the Rowan Salisbury Schools System.

Instructions:

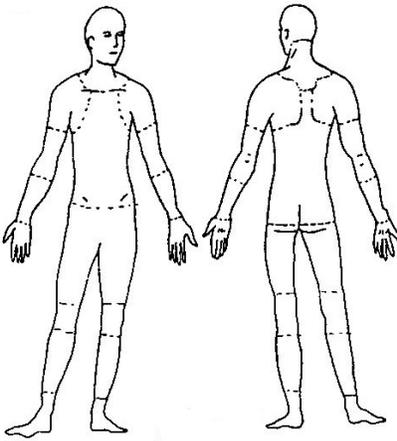
This form is to be completed anytime there is a reported injury, incident or near miss. Complete and submit to the Safety Department by the end of the day of the incident. Include all witness statements, employee statement, photos, etc.

Supervisor Incident Investigation Report

Instructions: Complete this form within 24 hours after an incident/ injury. Submit to Safety Department. Include all witness statements, employee statement, photos, etc.

This is a report of a: <input type="checkbox"/> Incident <input type="checkbox"/> Injury <input type="checkbox"/> First Aid Only <input type="checkbox"/> Near Miss	
Date of incident:	This report is made by: <input type="checkbox"/> Supervisor <input type="checkbox"/> Admin Team <input type="checkbox"/> Other_____

Step 1: Injured employee (complete this part for each injured employee)

Name:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Age:
Department:	Job title at time of incident:	
Part of body affected: (shade all that apply) 	Nature of injury: (most serious one) <input type="checkbox"/> Abrasion, scrapes <input type="checkbox"/> Amputation <input type="checkbox"/> Broken bone <input type="checkbox"/> Bruise <input type="checkbox"/> Burn (heat) <input type="checkbox"/> Burn (chemical) <input type="checkbox"/> Concussion (to the head) <input type="checkbox"/> Crushing Injury <input type="checkbox"/> Cut, laceration, puncture <input type="checkbox"/> Hernia <input type="checkbox"/> Illness <input type="checkbox"/> Sprain, strain <input type="checkbox"/> Damage to a body system: <input type="checkbox"/> Other _____	This employee works: <input type="checkbox"/> Regular full time <input type="checkbox"/> Regular part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Temporary
		Months with this employer

Step 2: Describe the incident

Exact location of the incident:	Exact time:
What part of employee's workday? <input type="checkbox"/> Entering or leaving work <input type="checkbox"/> Doing normal work activities <input type="checkbox"/> During meal period <input type="checkbox"/> During break <input type="checkbox"/> Working overtime <input type="checkbox"/> Other_____	
Names of witnesses (if any):	

Number of attachments:	Written witness statements:	Photographs:	Maps / drawings:
What personal protective equipment was being used (if any)?			
Describe, step-by-step the events that led up to the injury. Include names of any machines, parts, objects, tools, materials and other important details.			
Description continued on attached sheets: <input type="checkbox"/>			

Step 3: Why did the incident happen?	
Unsafe workplace conditions: (Check all that apply) <input type="checkbox"/> Inadequate guard <input type="checkbox"/> Unguarded hazard <input type="checkbox"/> Safety device is defective <input type="checkbox"/> Tool or equipment defective <input type="checkbox"/> Workstation layout is hazardous <input type="checkbox"/> Unsafe lighting <input type="checkbox"/> Unsafe ventilation <input type="checkbox"/> Lack of needed personal protective equipment <input type="checkbox"/> Lack of appropriate equipment / tools <input type="checkbox"/> Unsafe clothing <input type="checkbox"/> No training or insufficient training <input type="checkbox"/> Other: _____	Unsafe acts by people: (Check all that apply) <input type="checkbox"/> Operating without permission <input type="checkbox"/> Operating at unsafe speed <input type="checkbox"/> Servicing equipment that has power to it <input type="checkbox"/> Making a safety device inoperative <input type="checkbox"/> Using defective equipment <input type="checkbox"/> Using equipment in an unapproved way <input type="checkbox"/> Unsafe lifting <input type="checkbox"/> Taking an unsafe position or posture <input type="checkbox"/> Distraction, teasing, horseplay <input type="checkbox"/> Failure to wear personal protective equipment <input type="checkbox"/> Failure to use the available equipment / tools <input type="checkbox"/> Other: _____
Why did the unsafe conditions exist?	
Why did the unsafe acts occur?	
Is there a reward (such as “the job can be done more quickly,” or “the product is less likely to be damaged”) that may have encouraged the unsafe conditions or acts? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe:	
Were the unsafe acts or conditions reported prior to the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have there been similar incidents or near misses prior to this one? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Step 4: How can future incidents be prevented?

What changes do you suggest to prevent this incident/near miss from happening again?

- Stop this activity Guard the hazard Train the employee(s) Train the supervisor(s)
- Redesign task steps Redesign work station Write a new policy/rule Enforce existing policy
- Routinely inspect for the hazard Personal Protective Equipment Other: _____

What should be (or has been) done to carry out the suggestion(s) checked above?

Description continued on attached sheets:

Step 5: Who completed and reviewed this form? (Please Print)

Written by:

Title:

Department:

Date:

Names of investigation team members:

Reviewed by:

Title:

Date:

Risk Manager:

Reviewed Date:

