Rowan-Salisbury
SCHOOL SYSTEM
Extraordinary Education Every Day

Employee Incident Report
STAFF

CONFIDENTIAL

Rowan-Salisbury
SCHOOL SYSTEM
Extraordinary Education Every Day

Instructions: Have the employee complete pages 2-5 and email to Dawn Fox and copy Robin Faries. A supervisor will complete pages 8-11 and return to the Risk Manager and copy Robin Faries.

*** 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, illnesses, 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 complete by employees as soon as possible and given to a supervisor for further action.

*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? ☐ Yes ☐ No	**Prior authorization/insurance forms required before visiting clinic.
I am reporting a work related: ☐ Injury ☐ Incident ☐ Near miss	
Your Name:	
Job Title:	
Supervisor:	
Have you told your supervisor about this injury/near miss? ☐ Yes ☐ 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*** speak with someone in the Workers' Compensation Office first. They will advise where you will go to seek treatment.

FastMed Urgent Care, 1361 Klumac Rd, Salisbury
Promed Minor Emergency Clinic, 628 West Innes Street, Salisbury
Novant Health Rowan Medical Center Emergency Room

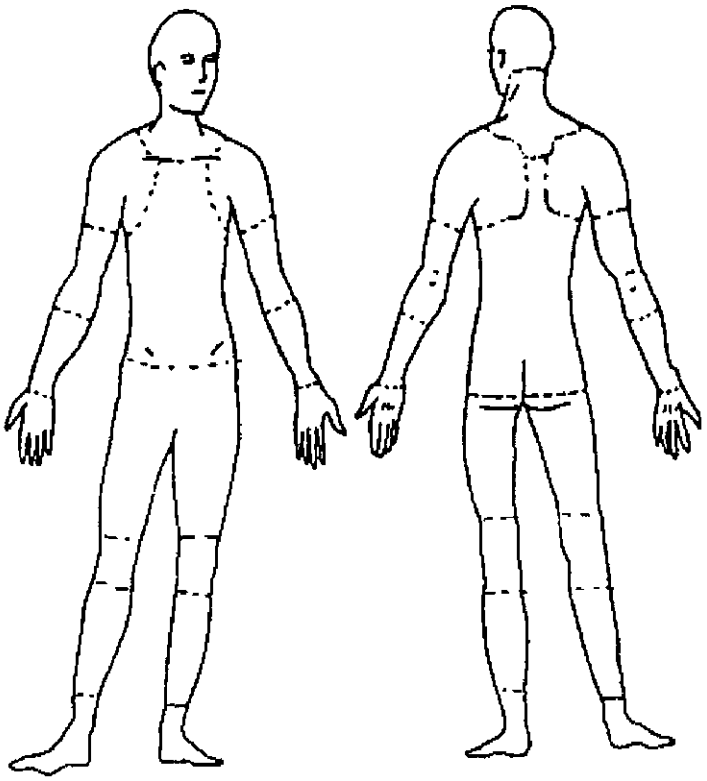
** You may not change doctors unless the last treating physician refers you to another doctor, which must be approved through the Workers' Compensation Office. You may not go to your family physician. **

Has this part of your body been injured before? ☐ Yes ☐ No	If yes, when?
Do you have other employent? ☐ Yes ☐ 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 my 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 complete for reimbursement. Request from Safety Department.

"THE ACT OF EMPLOYEES FILING A FRADULANT 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)

Rowan-Salisbury
SCHOOL SYSTEM
Extraordinary Education Every Day

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 release by any RSS employee, except for the Worker's Compensation Administrator or the Risk Manager for the Rowan Salisbury Schools System.

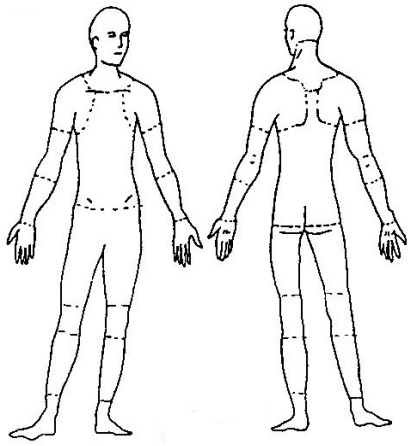
Instructions:
This form is to be completed anytime there is a reported injury, incident or near miss. Complete and submit to Safety Department by end of the day of the incident. Include all witness statements, employee statement, photos and etc.

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 and etc.…

This is a report of a: ❑ Incident ❑ Injury ❑ First Aid Only ❑ Near Miss	
Date of incident:	This report is made by: ❑ Supervisor ❑ Admin Team ❑ Other_____

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

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

Step 2: Describe the incident

Exact location of the incident:	Exact time:
What part of employee's workday? ❑ Entering or leaving work ❑ Doing normal work activities ❑ During meal period ❑ During break ❑ Working overtime ❑ 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: ❑

Step 3: Why did the incident happen?

Unsafe workplace conditions: (Check all that apply)
- ❑ Inadequate guard
- ❑ Unguarded hazard
- ❑ Safety device is defective
- ❑ Tool or equipment defective
- ❑ Workstation layout is hazardous
- ❑ Unsafe lighting
- ❑ Unsafe ventilation
- ❑ Lack of needed personal protective equipment
- ❑ Lack of appropriate equipment / tools
- ❑ Unsafe clothing
- ❑ No training or insufficient training
- ❑ Other: _____

Unsafe acts by people: (Check all that apply)
- ❑ Operating without permission
- ❑ Operating at unsafe speed
- ❑ Servicing equipment that has power to it
- ❑ Making a safety device inoperative
- ❑ Using defective equipment
- ❑ Using equipment in an unapproved way
- ❑ Unsafe lifting
- ❑ Taking an unsafe position or posture
- ❑ Distraction, teasing, horseplay
- ❑ Failure to wear personal protective equipment
- ❑ Failure to use the available equipment / tools
- ❑ 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? ❑ Yes ❑ No
If yes, describe:

Were the unsafe acts or conditions reported prior to the incident? ❑ Yes ❑ No

Have there been similar incidents or near misses prior to this one? ❑ Yes ❑ 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: Department:	Title: Date:
Names of investigation team members:	
Reviewed by:	Title: Date:
Risk Manager:	Reviewed Date:

Witness Statement Form

Witness's Name: _____ Date of Incident: _____

_____ _____ _____

Address City State

_____ _____ _____

Telephone Number Work mbeNu Other Numbers

_____ _____ Age: _____

Occupation Relationship

STATEMENT

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

The information I have provided in this report is true and correct to the best of my knowledge. I understand making false statements on this form is a criminal offense. If I am a RSS employee, I understand making a false statement will result in disciplinary action up to and including dismissal.

Date _____ Witness Signature _____