MOUNT VERNON SCHOOL DISTRICT NO. 320

EMPLOYEE INJURY REPORT

Today's Date:_____ Date of injury:_____ Date hired_____

Injured employee:_____ Date of birth:_____ __ Male __ Female

Address: _____ Home Phone _____

City _____ State: _____ Zip:_____

Scheduled work days and hours:_____Time of injury? _____ AM/PM

School/Site:_____ Position (teacher/IA, etc): _____

Exact location of injury (playground, classroom, etc.) _____

Part of body Injured (circle Right/Left)		Type of Injury:		Response/Result:	
☐ Head	☐ R. L. Hand	☐ Wounds	☐ Amputation	☐ Death	☐ Time Loss
☐ R. L. Eye	☐ R. L. Leg	☐ Strain & Sprain	☐ Burns	☐ First-Aid Only	
☐ Trunk	☐ R. L. Toe	☐ Hernia	☐ Foreign Body	☐ Sought Immediate Medical Treatment	
☐ R. L. Arm	☐ Internal	☐ Fracture	☐ Skin (occupational)	☐ Delayed Medical Treatment	

Remarks:_____ Remarks:_____ Remarks:_____

I. Eyewitness(es) (Please request they complete the Statement of Witness Form):

II. DESCRIBE ACCIDENT: Include the machine, equipment, object or substance involved. *ALL DETAILS…*

III. CAUSE: Mark basic cause ☐ Mark contributing cause, if any ☐

UNSAFE CONDITIONS	UNSAFE ACTS
☐ Inadequately guarded	☐ Operating without authority
☐ Unguarded	☐ Operating at unsafe speed
☐ Defective tools, equipment or substance	☐ Making safety devices inoperative
☐ Unsafe design or construction	☐ Using unsafe equipment or equipment unsafely
☐ Hazardous arrangement	☐ Unsafe loading, placing, mixing
☐ Unsafe illumination	☐ Taking unsafe position
☐ Unsafe ventilation	☐ Working on moving or dangerous equipment
☐ Unsafe clothing	☐ Distraction, teasing, horse play
☐ Insufficient instruction	☐ Failure to use personal protective devices

Why was the unsafe act committed? _____

Why did the unsafe condition exist? _____

Any physical disabilities? _____ Number of previous disability injuries (L & I)? _____

IV. GUIDES TO CORRECTIVE ACTION

Based on the cause checked above, I am taking the following corrective action:

UNSAFE ACT	UNSAFE CONDITION If supervisor can't handle, then recommend to:				
☐ Stop the worker	☐	Remove	☐	Administrator	
☐ Study the job	☐	Guard	☐	Safety Committee, or	
☐ Instruct (tell-show-try-check)	☐	Warn	☐	Maintenance dept. or	
☐ Follow-up	☐	Supervisory	☐	_____	
☐ Enforce	☐	Training	☐	Follow-up	

What I am actually doing to prevent similar injuries: _____

What further recommendations, if any: _____

- PLEASE SEE OTHER SIDE FOR ADDITIONAL QUESTIONS -

08/16

MOUNT VERNON SCHOOL DISTRICT NO. 320
EMPLOYEE INJURY REPORT

V. DETAILED ACCIDENT INFORMATION

What was the employee doing just before the incident occurred? Describe the activity, as well as the tools, equipment or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry", etc.

_____

_____

What happened? Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "worker was sprayed with chlorine when gasket broke during replacement"; "worker developed soreness in wrist over time", etc.

_____

_____

What was the injury or illness? Tell us the part of the body that was affected and how it was affected; be more specific than "hurt", "pain" or "sore". Examples: "strained back"; "chemical burn on hand"; "carpal tunnel syndrome", etc.

_____

_____

What object or substance directly harmed the employee? Examples: "concrete floor"; "chlorine"; "radial arm saw". If this question does not apply to the incident, please leave it blank.

_____

If the employee died, when did death occur? _____ / _____ / _____
month day year

VI. TREATMENT RESPONSE

Name of person who administered first aid: _____

If treatment was given away from the work-site, when was it given? Date & time_____

*Facility: _____

Address: _____

City:_____ State: _____ Zip:_____ Phone: _____

Was employee treated in an emergency room? Yes _____ No _____

Was employee hospitalized overnight as an in-patient? Yes _____ No _____

Was employee put on any restrictions? Yes_____ No _____

***Complete Employee Return to Work Status Form and attach APF**

Information about the case: Case number from L&I Report _____

_____ _____ _____ _____
Employee's Signature Date Supervisor's Signature Date

DISTRIBUTION: *Original: Personnel Department; Copies: supervisor, employee*

MOUNT VERNON SCHOOL DISTRICT

EMPLOYEE RETURN TO WORK STATUS

Employee _____ Location_____

Assignment_____ L&I Claim #_____ Date of Injury _____

I have met with my health provider. It has been determined that (select one):

____ I am released to return to work without any medical restrictions beginning on (date)_____. Attached is the Activity Prescription Form authorizing my return.

____ I am **NOT** released to return to work as of (start date)_____ to (end date)_____. Attached is the Activity Prescription Form authorizing my leave from work.

____ I am released to return to work **WITH** restrictions as of (start date)_____ to (end date)_____. Attached is the Activity Prescription Form detailing these restrictions and my health provider's response to the Employer's Job Description.

While I continue to receive care from my health provider and my claim remains open, I acknowledge my responsibilities as an employee of the Mount Vernon School District to:

- inform my supervisor when I have sustained an injury at work and fill out the Employee Injury Report as soon as possible.
- provide a note from my medical provider to my supervisor indicating my availability to return to work if I seek medical attention for my work-related injury or occupational disease.
- follow up with all of my appointments with my health provider and their recommendations during the period that I am under their care for my work-related injury or occupational disease.
- keep my supervisor informed of any changes to my work status placed on me by my health provider and provide Activity Prescription Forms each time I return from my medical appointments.
- report all L&I related absences through established procedures and on the appropriate payroll absence form(s).
- provide a Release to Return to Work to the MVSD Personnel Department once treatment and care for my work-related injury or occupational disease is concluded.

Failure to comply with these responsibilities may result in disciplinary action up to and including dismissal from employment.

_____ _____

Employee's Signature Date