

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:

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

Body part(s) injured _____ Right / Left
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 Pool. If you have or will be receiving treatment at a clinic or hospital for the above incident you need to contact your District Office to file a claim for benefits and obtain an SIF2 form.

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 _____

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 NCWWC Pool at the NCESD