ESD 101 Incident Report Form

(This is NOT a W/C benefits claim form)

Part One –To be completed by the injured employee.

Employee's Name: Last ____________________ First _______________________ Middle Initial______

Employee's Home Address: ____Home Phone: ________________

Gender: M ____ F ____ Date of Birth: ___________________ Social Security Number: ______________________

School District: _______________________________________ Job Title: ____

School: ______________________________________ Department: ______________________________________

Supervisor's Name and Job Title: ____

Date of Incident: _________________ Time of Incident: _____________________ Day of Week: ________________________

Date of Incident Report: ___________________________ Reported to Whom: _________________________

Specific location where incident occurred: ____

Witnesses: ____

Brief description of the accident or incident: ____

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Check the boxes below that describe your injuries:

	Left	Right	Upper	Lower		Left	Right	Upper	Lower
Head					Wrist				
Neck					Finger				
Shoulder					Leg				
Chest					Knee				
Abdomen					Ankle				
Back					Toe				
Arm					Other				

Describe your injuries: ____

____

____

____

Did you, the injured employee, receive first-aid? Yes _____ No _____

Did you, the injured employee, see a doctor? Yes _____ No _____

If yes, list the doctor's name, address: ____ Phone ___________________

Have you already filed a claim form? (This is NOT a claim form.) Yes _____ No _____

Did you miss work as a result of this incident? Yes _____ No _____

If yes, list the date(s): ____

Employee's Signature: ____ Date: ______________________________

If you are injured at work and see a doctor, you must call 509-789-3516 or 1-800-531-4290 to file a claim for Worker's Compensation.

Part Two – To be completed by the injured employee's supervisor.

Supervisor's Comments – Describe the incident in your own words: ____

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What could have been done to prevent this accident/incident? ____

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Have all unsafe conditions been corrected? Yes _____ No _____

If yes, what has been done? ____

If no, what needs to be done? ____

Have all unsafe activities been addressed? Yes _____ No _____

If yes, what has been done? ____

If no, what needs to be done? ____

Has Personal Protective Equipment (PPE) been provided as a result of the incident? Yes _____ No _____

List the PPE: ____

If yes, who received the additional PPE? ____

Has additional training been provided as a result of this incident? Yes _____ No _____

If yes, who received the additional training? ____

Employer or Supervisor's signature: _________________________________ Date: _______________________

Additional comments/notes: ____

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The injured worker must complete Part One and submit it to his/her supervisor.

The injured worker's supervisor must:

- Perform an investigation of the incident
- Complete Part Two of this form, and
- Submit the entire report of the ESD 101 Risk Manager

Submit this form as soon as possible after an accident or incident—

Mail this form to: Risk Manager, ESD 101
4202 S Regal Street
Spokane, WA 99223

OR, fax this form to: 509-456-2999

Submit additional copies of this completed form to:

- Your School District Administration Office, and
- Your building's Safety Committee Chairperson