Employee Incident Report

EMPLOYEE INFORMATION

Name: _____ S #: _____
Job Title: _____ Department: _____
Work Phone #: _____ Time you began work on the day of the incident: _____
What hours do you normally work? (please indicate a time frame (i.e.: 8:00-4:30) _____

INCIDENT INFORMATION

DATE OF INCIDENT: _____ **TIME OF INCIDENT:** _____
DATE REPORTED: _____ TIME REPORTED: _____
Incident initially reported to: _____ Phone #: _____
Were you performing your normal occupation at the time of the incident? ☐ Yes ☐ No
If no, please explain: _____

Location where incident occurred (**please include physical address)**: _____

Were there any witnesses? ☐ Yes ☐ No
If yes, list names and contact numbers: _____

Were there any safety hazards? ☐ Yes ☐ No If yes, please explain: _____

How did the incident happen? Describe specific activity you were performing at the time incident occurred, including, tools, equipment, or materials used:

Describe the part of body affected & **how** affected (please be specific with how your injury is affecting you, i.e.: sprain, fracture, contusion, etc.)

Have you injured this part of your body previously? ☐ Yes ☐ No
If yes, please explain: _____

Did you leave work following the incident? ☐ No ☐ Yes
If yes, what date and time did you return? Date: _____ Time: _____
Have you previously filed an injury claim? ☐ No ☐ Yes Date/Details: _____

IMPORTANT INFORMATION

Do you require medical attention now? ☐ Yes ☐ No

Please sign and date below and give this form to your Supervisor or site office ***immediately.*** Unless this is a true medical emergency, you may not seek treatment before consulting with the HR Department.

If medical attention is not needed now for this incident, but is necessary at a later date, you **MUST** contact Human Resources at 530-938-5317 prior to seeking or obtaining treatment.

Failure to report occupational injuries in a timely manner may result in a delay of any possible workers' compensation benefits while College of the Siskiyous and the insurance carrier investigate your claim.

**Any person who makes or causes to be made any knowingly false or fraudulent material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Employee signature: _____ Date signed: _____

Name of person completing this form if employee is unable to do so: _____
Signature: _____ Date signed: _____
Job Title: _____ Phone #: _____

***If you are involved in a Motor Vehicle Accident you will also need to fill out an INS-8 form and return it with this form.**
Please indicate if you have filled out the INS-8 form: ☐ Yes ☐ N/A

RETURN COMPLETED REPORT TO THE HUMAN RESOURCES OFFICE
OR
FAX THIS COMPLETED REPORT *IMMEDIATELY* TO 530-938-5245

DO NOT DELAY IN REPORTING INJURIES TO THE HUMAN RESOURCES DEPARTMENT