Incident Analysis
Workplace Injury Report

Risk Mgmt. Verification Use Only
Date Received / /
Confirmed/File ☐ Yes ☐ No

INSTRUCTIONS

1. **To be processed by supervisor or designee, otherwise known as the Workers' Compensation Site Contact.**
2. **Supervisor/Designee will call Risk Management at 830-4247 immediately after an accident has been reported.**
3. **With the assistance of the injured employee, WC Site Contact will complete this form while at the *same time and location*; injured employee will complete Workers' Compensation Employee Statement.**
4. **Supervisor/Designee will fax completed Incident Analysis Workplace Injury Report along with the Workers' Compensation Employee Statement to the Risk Management office at 252-756-7258 within one hour of accident.**
5. **If applicable, please fax Accident Witness Statement and School Nurse Assessment along with other forms/documentation.**

PREPARER'S INFORMATION

I, ______________________________, understand this form, and accept it as the terms of my responsibility in the Workers' Compensation claim process. As the Workers' Compensation Site Contact, I also understand that I am required to ensure all claim forms are completed and submitted to the Risk Management Office as instructed.

INJURED EMPLOYEE INFORMATION

Name of employee: ______________________________ DOB: ______________

Occupation: School/Site:

INCIDENT/ACCIDENT INFORMATION

Date of incident:	Time of incident:	☐ A.M. ☐ P.M.

Specific Location of incident:
(e.g. building name, room number, parking lot area, etc.)

Injury Description:
(e.g., No Injury, sprain Lt. ankle, etc.)

Medical Treatment?
/ ☐ None Required ☐ First Aid Only ☐ School Nurse Assessment (Verify Availability)
\ ☐ *PCS Authorized Medical Provider ☐ *Emergency Treatment

**Upon receipt of employee's request for medical treatment, the Risk Management Office will provide authorization forms for treatment at Pitt County Schools' preferred provider. Employee must present a doctor's note/work status report immediately following treatment or as soon as reasonable to the Risk Management Office.*
*If it is determined that the injury is not a compensable claim under the Workers' Compensation Act, **employee may be responsible** for all medical expenses incurred.*

Did injured leave work prior to regular leave time to seek medical treatment?	☐ Yes ☐ No	If yes, Enter Regular Leave Time: Enter Actual Leave Time:

Effective 8/23/2016

CLAIM SUMMARY:

Describe the injury and how it occurred. Describe the activity, as well as the tools, equipment, or material the employee was using. List the sequence of events, including employee's activity prior to accident and the factors leading up to the accident.

VALIDITY OF CLAIM:

Do you question the validity of this claim or parts therein? ☐ Yes ☐ No

If yes, enter reason here: ______________________

CONTRIBUTING FACTORS (check below those that apply):

Physical Sources	Unsafe Behaviors
☐ Poorly maintained tools or equipment	☐ Inadequate instructions
☐ Poor housekeeping, slippery floor, or tripping hazard	☐ Did not use assigned personal protective equipment
☐ Unguarded equipment	☐ Did not follow rules or instructions
☐ Crowded work conditions	☐ Circumvented safety features
☐ Poor storage practices	☐ Used poorly maintained tools and machinery
☐ Personal protection and clothing not adequate for hazards	☐ Failed to follow established procedures and work practices
☐ Insufficient lighting or ventilation	☐ Unable to physically perform work
☐ Cold or Hot temperatures	☐ *Other contributing behaviors – Explain Below
☐ *Other contributing conditions – Explain below	
*	*

MEASURES TO AVOID RECURRENCE

Describe actions to take to avoid recurrence: ______________________

WITNESS INFORMATION (ADULT WITNESS ONLY)

Please provide witness information below and issue each adult witness an Accident Witness Statement and request back completed within one hour in preparation to submit to Risk Mgmt. Office.

		Witness Statement	
		Time Issued	Time Returned
1. Name:	**Phone Number:**		
2. Name:	**Phone Number:**		

Signature ______________ Title ______________ Date ______________