INCIDENT ANALYSIS WORKPLACE INJURY REPORT

INSTRUCTIONS:

1. To be prepared by Supervisor or Workers' Comp Rep at the schools level.
2. Supervisor/Workers Comp Rep will call Risk Management at (252)830-4211 or (252)406-5069 immediately after the accident has been reported.
3 .With the assistance of the injured employee, Workers Comp Rep will complete this form while at the same time and location; the injured employee will complete Workers' Compensation Employee Statement.
4 . Workers' Comp Rep will email the Incident Analysis Workplace Injury Report along with the Workers' Compensation Employee Statement and Workers' Comp Acknowledgement Form to workerscomp@pitt.k12.nc.us within one hour of the accident.
5. If applicable, please email the Accident Witness Statement along with other forms.

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 Rep, 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:	☐ AM ☐ PM
Specific Location of incident: (e.g. building name, room number, parking lot area etc.)		
Injury Description: (e.g. no injury, sprained left ankle, etc.)		
Initial Medical Treatment: ☐ None Required ☐ Refused ☐ First Aid Only ☐ *PCS Authorized Provider ☐ * Emergency Treatment	*Compensation Act, the employee may Upon receipt of employee request for medical treatment, the Risk Management Office will provide authorization forms for treatment at PCS authorized provider. Employee must present a doctor's note/work status report immediately following treatment to the Risk Management Office. If it is determined that the injury is not a compensable claim under Workers' be responsible for all medical expenses incurred.	
Did injured leave work prior to regular time to seek medical treatment? ☐ Yes ☐ No	If Yes, Enter regular leave time/Actual leave time _____/_____	

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 the accident and the factors leading up to the accident.

_____

VALIDITY OF CLAIM:

Do you question the validity of the claim or parts therein?

☐ Yes ☐ No

If yes, enter your reason here:

CONTRIBUTING FACTORS: (check below all that apply)

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

MEASURES TO AVOID RECURRENCE:

Describe actions to take to avoid recurrence: