NATOMAS UNIFIED SCHOOL DISTRICT
EMPLOYEE INCIDENT REPORT

Employee Name_____ Date of Birth_____

Address_____ Home Phone_____

_____ Male_____ Female_____

Job Title_____ School Site_____

Date of injury_____ Time of day _____

Where did accident or exposure occur? *(Number and street and/or building)*

_____

What was the employee doing when injured? *(Be specific: identify tools, equipment, and materials being used).*

_____

_____

How did the accident or exposure occur? *(Describe fully the events that resulted in injury or occupational disease. Tell what happened and how it happened.)*

_____

_____

_____

_____

Object or substance that directly injured employee *(e.g. the machine employee struck against or which struck him/her; the vapor or poison inhaled or swallowed; the chemical that irritated his/her skin):*

_____

Describe the injury or illness *(e.g. cut, strain, fracture, rash, etc.)*:

_____

Please email completed form to lwestlake@natomasunified.org or fax to 916-567-5453

Part of the body affected *(e.g., back, left wrist, right eye, etc.)*

_____

Did employee lose at least one full day of work? Yes____ No____

Witness names and contact information:

Name_____ Phone _____

Name_____ Phone _____

It is unlawful to: (a) present or cause to be presented any false or fraudulent claim for the payment of a loss under a contract of insurance, (b) prepare, make or subscribe any writing with intent to present or use the same or allow it to be presented or used in support of any such claim. Every person who violates any provision of this section is punishable by imprisonment in the state prison not exceeding three years or by fine not exceeding one thousand dollars or by both.

_____ _____

Signature of person filling out form ***Date***

_____ _____

Supervisor's Signature ***Date***

If the employee is requesting medical treatment, confirm the date the injury was reported to the EIN (1-877-742-3467)

Date Reported:

If the employee is NOT requesting workers' compensation benefits, sign here to acknowledge:

At this time, I am not seeking workers' compensation benefits, i.e. medical treatment, temporary disability payments, etc. I will immediately advise my supervisor and the Early Intervention Nurse (EIN) if I later wish to place a claim for benefits as a result of this incident.

Signed By:	*Date:*