EMPLOYEE INCIDENT REPORT

(Print on blue paper)

ALL INCIDENTS SHOULD BE REPORTED ON AN INCIDENT FORM AND SUBMITTED TO THE BUSINESS OFFICE WITHIN 24 HOURS. IF THE INJURED EMPLOYEE DOES NOT SEE A DOCTOR IMMEDIATELY, BUT IT IS THE TYPE OF INJURY WHICH COULD CAUSE PROBLEMS LATER, A REPORT MUST ALSO BE FILED.

EACH INCIDENT SHOULD BE INVESTIGATED WHETHER THE RESULT WAS SERIOUS OR NOT. THE OBJECT IS TO PREVENT RECURRENCES AND IT IS ONLY BY THOROUGH INVESTIGATION THAT THE REAL CAUSE CAN BE DETERMINED AND CORRECTED.

NAME OF INJURED EMPLOYEE (Last, First, M.I.) SOCIAL SECURITY NUMBER

STREET ADDRESS	CITY, ZIP CODE	HOME TELEPHONE
POSITION	DATE OF INCIDENT	TIME OF DAY
BUILDING/SCHOOL WHERE ACCIDENT OCCURRED	DATES ABSENT FROM WORK DUE TO INJURY	DATE EMPLOYEE WILL RETURN TO WORK

GIVE A DESCRIPTION OF INJURY (TWISTED LEFT ANKLE, CUT RIGHT HAND, ETC.):

_____

DESCRIBE HOW INCIDENT OCCURRED

_____

DID THE EMPLOYEE SEE A DOCTOR OR GO TO THE HOSPITAL? ☐ YES ☐ NO ("X" ONE)

IF YES, FILL IN THE FOLLOWING INFORMATION AND HAVE PHYSICIAN COMPLETE "RETURN TO WORK RECOMMENDATIONS RECORD", WHICH CAN BE OBTAINED IN THE SCHOOL OFFICE OR THE BUSINESS OFFICE:

DOCTOR OR HOSPITAL

DOCTOR	HOSPITAL
NAME ______________________	NAME ______________________
ADDRESS ______________________	ADDRESS ______________________
DATE OF SERVICE ______________________	DATE OF SERVICE ______________________

WERE THERE ANY WITNESSES TO THIS INCIDENT? ☐ YES ☐ NO ("X" ONE)
IF YES, COMPLETE THE FOLLOWING:

NAME OF WITNESS(ES)	ADDRESS	TELEPHONE

PLEASE ANSWER THE FOLLOWING QUESTIONS. CHECK "YES" OR "NO". INDICATE N/A IF QUESTION DOES NOT APPLY.

1.	WAS INJURED PERSON PROPERLY INSTRUCTED IN SAFE EFFICIENT METHODS?	☐ YES	☐ NO
2.	DID HE/SHE VIOLATE ANY INSTRUCTIONS?	☐ YES	☐ NO
3.	WAS NECESSARY PROTECTIVE EQUIPMENT WORN? (GOGGLES, SAFETY BELT, HARD HAT, ETC.)	☐ YES	☐ NO
4.	DID POOR HOUSEKEEPING CONTRIBUTE TO THE INCIDENT?	☐ YES	☐ NO
5.	DID "HORSEPLAY" CAUSE THE INCIDENT?	☐ YES	☐ NO
6.	WAS IT CAUSED BY SOMETHING WHICH NEEDED REPAIR?	☐ YES	☐ NO
7.	SHOULD A GUARD BE PROVIDED?	☐ YES	☐ NO
8.	DID ANY BODILY DEFECT CONTRIBUTE TO THE INCIDENT?	☐ YES	☐ NO
9.	WAS ACCIDENT CAUSED BY AN UNSAFE ACT?	☐ YES	☐ NO
10.	DID INJURED PERSON REPORT TO FIRST AID IMMEDIATELY?	☐ YES	☐ NO

WHAT DO YOU CONSIDER THE REAL CAUSE OF THIS INCIDENT (NAME OBJECT OR SUBSTANCE DIRECTLY CONTRIBUTING TO INCIDENT): ______________________________

____

WHAT STEPS ARE BEING TAKEN TO PREVENT SIMILAR INCIDENTS: ____________________

____

PERSON MAKING REPORT:

NAME ______________________ TITLE ________________ DATE __________

PRINCIPAL/DIRECTOR/SUPERVISOR ______________________ DATE __________
(SIGNATURE)

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Date Received by Business Office ______________

Medical Service Form

________________________________reported an injury on___________________
(Name of Employee) (Date)
while at work at the Waukesha School District.

The nature of the reported injury to be treated is_______________________________
(Nature of Injury)
____

Please forward all bills to our Workers Compensation carrier at the address below:

Liberty Mutual Insurance
P.O. Box 8016
Wausau, WI 54402
Phone: (800) 826-1661 ext. 8204
Fax: (603) 334-8157

Waukesha School District is committed to preventing workplace injuries, controlling injuries that do occur, and providing modified duties after an injury. We offer many types of alternative work and/or transitional work which allows the injured employee to work within their medical restrictions. Our belief is that it is in the best interest of Waukesha School District employees to return to work as soon as they are physically able. Working together with the physician, injured employees can heal and return more quickly to productive employment.

Attached is a *"Fitness for Duty Form"* to list any applicable work restrictions. Please complete this form and give to the employee. After treatment, the employee returns this form to me or you can fax directly to me using the fax cover sheet on the back of this letter.

If you have any questions regarding this injury or alternative duties available, please call me.

Thank you for your assistance.

Laurie Dudley
Waukesha School District
222 Maple Ave
Waukesha, WI 53186

Phone: (262) 970-1046
Fax: (262) 970-1020

ATTENDING PHYSICIANS
RETURN TO WORK RECOMMENDATIONS RECORD

Waukesha School District

Patient's Name (Last) (First) (Middle Initial)	Date of Injury/Illness

TO BE COMPLETED BY ATTENDING PHYSICIAN - PLEASE CHECK

DIAGNOSIS/CONDITION (Brief Explanation)

I saw and treated this patient on___________ and based on the above description of the patient's current medical problem:
Date

1. ☐ Recommend his/her return to work with no limitations on____.
Date

2. ☐ He/she may return to work on________________________________with the following limitations:
Date

CHECK ONLY AS RELATES TO ABOVE CONDITIONS

☐ **Sedentary Work.** Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.

☐ **Light Work.** Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

☐ **Light Medium Work.** Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds.

☐ **Medium Work. Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.**

☐ **Light Heavy Work. Lifting 75 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds.**

☐ **Heavy Work. Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds.**

1. In an 8 hour work day patient may:
   a. Stand/Walk
   ☐ None ☐ 4-6 Hours
   ☐ 1-4 Hours ☐ 6-8 Hours

   b. Sit
   ☐ 1-3 Hours ☐ 3-5 Hours ☐ 5-8 Hours

   c. Drive
   ☐ 1-3 Hours ☐ 3-5 Hours ☐ 5-8 Hours

2. patient may use hand(s) for repetitive:
   ☐ Single Grasping ☐ Pushing & Pulling
   ☐ Fine Manipulation

3. Patient may use foot/feet for repetitive movement as in operating foot controls:
   ☐ Yes ☐ No

4. Patient may:

	Not at All	Occasionally	Frequently
a. Bend	☐	☐	☐
b. Twist	☐	☐	☐
c. Squat	☐	☐	☐
d. Climb	☐	☐	☐
e. Reach	☐	☐	☐

OTHER INSTRUCTIONS AND/OR LIMITATIONS - INCLUDING PRESCRIBED MEDICATIONS

3. ☐ These restrictions are in effect until_________________________or until patient is reevaluated on________________________________
Date Date

4. ☐ He/she is totally incapacitated at this time. Patient will be reevaluated on____________________________________
Date

5. ☐ Referred To: ☐ None Private Physician____
Doctor
☐ Return Here_________________________ ☐ A Consultant____
Date & Time Doctor, Date & Time

Physician's Signature	Date

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize my attending physician and/or hospital to release any information or copies thereof acquired in the course of my examination or treatment for the injury identified above to my employer to his representative.

Patient's Signature	Date