North Coast Schools' Insurance Group

901 Myrtle Avenue • Eureka, California 95501-1294 • 707/445-7126 • FAX 707/445-7084

SERVING DEL NORTE COUNTY AND HUMBOLDT COUNTY SCHOOLS

Incident Report

Incident Reporting ensures there is a record on file with the employer. In no way does this waive the employee's right to workers' compensation benefits. If an injury occurs, first aid may be appropriate treatment. "First aid" means any one-time treatment and any follow-up visit for the purpose of observation of minor scratches, cuts, burns, splinters, or other minor industrial incident, which do not ordinarily require medical care. This one-time treatment and follow-up visit for the purpose of observation is considered first aid even though provided by a physician or registered professional personnel. Filing of the first aid incident report is not a filing of a worker's compensation claim. An employee retains the right to file a workers' compensation claim at a later date. If, initially, first aid is rendered but at a later date treatment beyond first aid is required, the employee must immediately report this to their supervisor and initiate the filing of a workers' compensation claim.

First Aid, as defined by the California Labor Code and Regulations, is any one-time treatment, and any follow-up visit, for the purpose of observation of minor scratches, cuts, burns, splinters or other minor occupational injuries, which do not ordinarily require medical care. Such one-time treatment, and follow-up visit for the purpose of observation, is considered First Aid, even though provided by a physician or by other registered professional personnel.

Please contact Keenan & Associates at 707.268.1616 if you have any administrative questions.

Signature of Employee Date

Signature of Supervisor Date

Medical Provider

Please complete and give to the employee to return to their supervisor:

_____ This visit is for First Aid only with no follow up visits or time off work.

_____ This visit is for First Aid only with one follow up visit and no time off work.

_____ This claim is for more than First Aid and should be submitted as a claim under Workers' Compensation.

Signature of Provider Date

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FIRST AID INCIDENT REPORT

Workers' Compensation Program

This report to be completed when an occupational illness or incident occurs. If an employee is injured or develops a job-related illness (developed gradually e.g., tendonitis) as a result of their employment, they must complete and submit this report. If the employee is unable to complete the form, the supervisor must complete it on their behalf.

If you have any questions, please call Keenan & Associates at 268-1616,
or visit the North Coast Schools' Insurance Group Web site at http://ncsig.org

EMPLOYEE INFORMATION – TO BE COMPLETED BY EMPLOYEE

Please complete each section. When you have completed the form and are satisfied with your answers please give this form to your supervisor.

Name:		Employee ID#:	
Local Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	
Department:	Job Title		
Hours Worked: Days per Week:	Hours per Week:		
Do you have other employment? ☐ Yes ☐ No If so, where:			

INCIDENT INFORMATION

Date of Incident:	Time of Incident:
Date Incident Reported:	Incident Reported to:
Address/Bldg. name & room # where incident occurred:	
Type of Injury (e.g., laceration, strain, etc.):	Part of Body (e.g., left, right, eye, arm, etc.):
Describe how incident occurred:	
Please list the name(s) and phone number(s) of any witnesses:	
Is this a new injury? ☐ Yes ☐ No If "no", please indicate date of original injury:	

INITIAL MEDICAL TREATMENT

Was treatment received? ☐ No medical treatment-reporting only ☐ First Aid ☐ Treatment was/will be provided by:
Medical Facility: Doctor/Provider Name:

I, the injured employee, herein certify the information above is true and to best of my knowledge

Signature of Employee:	Date:

SUPERVISOR INFORMATION – TO BE COMPLETED BY SUPERVISOR OR DESIGNEE

Please complete this form within 24 hours of your first notice of incident, and fax (268-8963) or forward via email to Keenan & Associates.

Supervisor Name:	Supervisor Title:
Work Phone:	Email Address:

INCIDENT INFORMATION

Did employee lose time from work? ☐ Yes ☐ No ☐ Unknown If 'yes': First day of lost time:

Description of injury:

Was there equipment involved? ☐ Yes ☐ No If "yes" what was the equipment:

Were other employees injured: ☐ Yes ☐ No Name(s):

What action will be taken to prevent recurrence?

Other Comments:

Signature of Supervisor:	Date:

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