EMPLOYEE INCIDENT REPORT (EIR)

PART I: *To be completed by* EMPLOYEE

If you seek medical treatment, call ESD 114 Workers' Compensation Trust at 1-800-643-4369 to file a claim. Our department requires that this form be completed in its entirety in order to properly track incidents. Thank you.

Incident Date_____ Hour _____ ☐☐ am/pm Work Phone _____

School District _____ School Name (where injury occurred) _____

Employee's Name _____ Social Security Number _____

Address _____ City _____ Zip _____

Home Phone _____ Date of Birth _____ Marital Status / Dependents _____

Reporting Dept._____ Job Title _____ Shift Hours _____ to _____
(Food Service, Transportation, Maintenance, etc.)

Please mark the applicable category with an X:

☐ Have not received first aid or medical treatment at this time, but may want to file a claim at a later date.

☐ Received first aid (If YES, please describe type and by whom) _____

☐ Will or have received medical treatment (**Phone 1-800-643-4369 to file a claim** and add the provider's information below):

_____
If receiving medical treatment complete: (Medical Provider's Name / Clinic / Hospital) (Phone Number) (City)

Reported the Incident to _____ Date Reported _____

Name(s) of Witness (es) _____

Did Incident Occur On or Off School Premises? _____Were You Doing Your Regular Work? _____

Where Did Incident Occur? _____
(Breezeway, classroom, garage, grounds, etc.)

Description of Incident (include task being performed; step by step detail of incident; any tool/object involved): _____

_____

_____

Injury _____ Body Part Injured _____ RIGHT or LEFT ☐ ☐
(Bruise, sprain, strain, wound, etc.)

EMPLOYEE SIGNATURE _____ Date _____

PART II: *To be completed by* the SUPERVISOR **Send to District Office/HR* within 2 days of incident**

Date Investigated _____ Equipment Damaged? YES or NO If yes, describe: _____

Describe incident per your findings: _____

_____

Could the incident have been prevented? Yes☐ or No☐ If yes, how? _____

Describe what was found unsafe (Employee actions, equipment, lighting, clutter etc.) _____

_____

Follow up action to be taken _____ by whom _____ Date _____

Last date worked _____ Return to work date _____ is light duty work available? YES or NO

Supervisor Name (please print) _____ Date _____

SUPERVISOR SIGNATURE _____ Phone # _____

Olympic ESD 114 Workers' Compensation Trust
105 National Avenue N, Bremerton, WA 98312
*Email to workcomp@oesd114.org or Fax: (888) 558-1666 upon receipt

COPIES to Safety Committee and District Office as marked

Revised 04/04/2022