WORKPLACE INJURY INCIDENT REPORT

When should I fill out this form?

WFPS staff should complete this form if they are injured on the job. All on-the-job injuries must be reported the same day as the injury.

All signed injury incident report forms must be scanned and emailed or faxed to Human Resources at 701-499-6685.

What is a reportable injury?

A reportable injury is as follows;

- Any work-related injury or illness requiring medical treatment or that may require medical treatment **beyond first aid. (see below)**
- Any work-related injury involving a needlestick, bite or puncture that breaks the skin.
- Any work-related injury that results in fractured or cracked bones or teeth.
- Any work-related injury or illness that results in loss of consciousness.

*Injuries requiring First Aid do **not** require completion of a Workplace Injury Incident Report unless one of the additional criteria above are met in addition.*

First Aid is defined as follows:

· Using a non-prescription medication at nonprescription strength
· Cleaning, flushing or soaking wounds on the surface of the skin
· Using wound coverings such as bandages, Band-Aids™, gauze pads, etc.; or using butterfly bandages or Steri-Strips™ (other wound closing devices such as sutures, staples, etc., are considered medical treatment);
· Using hot or cold therapy;
· Using any non-rigid means of support, such as elastic bandages, wraps, non-rigid back belts, etc. (devices with rigid stays or other systems designed to immobilize parts of the body are considered medical treatment);
· Drilling of a fingernail or toenail to relieve pressure, or draining fluid from a blister;
· Using eye patches;
· Removing foreign bodies from the eye using only irrigation or a cotton swab;
· Removing splinters or foreign material from areas other than the eye by irrigation, tweezers, cotton swabs or other simple means;
· Using finger/arm guards;
· Drinking fluids for relief of heat stress

DESIGNATED MEDICAL PROVIDERS

WFPS has implemented a Workforce Safety & Insurance Safety Return-to-Work/Designated Medical Provider Program. This program requires WFPS to designate medical providers to treat your workplace injuries and illnesses.

If you are injured and need medical treatment contact one of the current providers for WFPS listed below:

- Sanford Health Occupational Medicine Clinic 3838 12 Ave N, Fargo 701-234-4700
- Essentia Clinic Occupational Health Program 1401 13 Ave E, West Fargo 701-364-5751

*Workforce Safety & Insurance may **not** pay for medical treatment to other providers **unless** you are referred by the designated provider or you specify a different provider in writing **prior to** the occurrence of injury or work-related illness.*

***Emergency care is exempt** from this designated provider requirement.

To add other medical provider(s) to your list of designated medical providers, please complete the **DMP Notification Form** and submit to Human Resources.

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EMPLOYEE CLAIMS MANAGEMENT CHECKLIST

Make sure the following steps are taken if you are injured on the job.

1. _____ Report your injury to your supervisor immediately.

2. _____ Seek first aid, if necessary.

3. _____ Complete and submit the Incident Report immediately. The district office needs to electronically file this report within **1 business day from the time the incident occurred.**

4. _____ If you need medical attention, proceed to a designated medical provider. If you have placed an additional designated medical provider on file with the Human Resources, you may proceed to that provider.

5. _____ Complete the First Report of Injury Form available online from Workforce Safety & Insurance.

6. _____ Complete the Hearing and Noise Questionnaire for any claims related to hearing loss, if instructed by Workforce Safety & Insurance.

7. _____ The Capability Assessment Form (C3) form is to be **completed by the doctor** and then returned to your employer after **each** visit.

8. _____ Keep receipts for medicine and mileage, and other items you pay for that are necessary for your care.

9. _____ Stay in constant touch with your employer and claims analyst with updates on your condition.

10. _____ Ask your doctor if you can return to work, even if you have some restriction on your work duties. Your employer has a Return to Work Program and does offer light duty.

11. _____ Notify Workforce Safety & Insurance immediately when you return to work, change addresses or telephone numbers or if you file for Social Security.

WORKPLACE INJURY INCIDENT REPORT

Today's Date_____ Employee Name _____

Location _____ Job Title_____

Date of Injury_____Supervisor_____

Any Witnesses_____

Please complete this form as fully and accurately as possible.

ACCIDENT ANALYSIS: Explain what occurred immediately before, during and following the incident.

What is the physical description of the injury? (Complete in detail)

What Body Part(s) is injured? (Specify **Right, Left or Both**) _____

☐ Ankle	☐ Lower Arm	☐ Upper Arm	☐ Back(middle)	☐ Back(lower)
☐ Buttocks	☐ Chest	☐ Ear	☐ Elbow	☐ Eye
☐ Face	☐ Finger(index)	☐ Finger(middle)	☐ Finger(ring)	☐ Finger(little)
☐ Foot	☐ Groin	☐ Hand	☐ Head	☐ Heel
☐ Hip	☐ Knee	☐ Leg(lower)	☐ Leg(upper)	☐ Mouth
☐ Neck	☐ Nose	☐ Ribs	☐ Shoulder	☐ Thumb
☐ Toe(big)	☐ Toe(little)	☐ Toe(other)	☐ Wrist	☐ Other_____

How did the incident occur? (In complete detail, attach an extra sheet if needed)

Were any machines or equipment involved?

Was an unsafe act or condition in some way responsible for this accident?

Can anything be done to keep a similar incident from occurring in the future? (change behavior, repair equipment or structure, add safety or training measure)

Is there anything that your supervisor can do to assist?

_____

Employee Signature Date

_____

Supervisor Signature Date

MEDICAL TREATMENT WAIVER

After completing this report, I declare that medical treatment **is not** necessary at this time.

_____

Employee Signature Date

MEDICAL TREATMENT REQUIRED - Please indicate which medical facility, you will be treated at:

☐ Sanford Occupational Health – 3838 12 Ave N, Fargo

☐ Essentia Clinic Occupational Program – 1401 13 Ave E, West Fargo

☐ Other: Only if already designated with HR _____

Please list facility name above

*Workforce Safety & Insurance will **not** pay for medical treatment to any other provider unless an alternate provider has been designated in writing **prior to** the occurrence of an injury or work-related illness.*

SUPERVISOR'S INVESTIGATION REPORT

Employee Name: _____

Position: _____ School: _____

Date of Incident: _____

Was the completed Incident Report submitted to Human Resources within 1 business day from the date of injury?

☐ Yes ☐ No

If no, why not? ***Incidents reported beyond 1 day from the date of injury cost the district $250 per incident.***

After investigating this incident, did you find that any safety equipment and/or training needed to be implemented to prevent the incident from occurring in the future?

List any corrective action taken:

Investigated by: _____ Date: _____

District Office only:

Incident entered by: _____ Date: _____