

# 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 or 360-782-5073 to file a claim

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 or 360-782-5073 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.) (Circle one or both)

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? \_\_\_\_\_

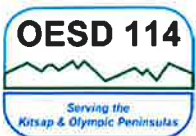
Describe what was found unsafe (Employee actions, equipment, lighting, clutter etc.) \_\_\_\_\_

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**

\*Upon receipt send top page to OESD 114 WCT or Fax: (888) 558-1666  
COPIES to Safety Committee and District Office as marked