Meridian School District
EMPLOYEE INJURY/ILLNESS REPORTING PROCEDURES
Checklist

- Employees are to immediately report ALL INJURIES TO THE PRINCIPAL OR SUPERVISOR prior to the close of the workday in which they occur. Failure to do so may result in disciplinary action.

- Any time an employee misses work due to an accident or illness suffered on the job, the employee must notify the payroll specialist by telephone within 24 hours.

When an employee is injured on the job, **AND DOES NOT REQUIRE MEDICAL ATTENTION**, the following must occur:

- Employee must complete ***Employee's Report*** (attached) and submit to supervisor.

- Supervisor must complete the ***Supervisor's Report*** (attached) and forward with the ***Employee's Report*** to the District Office.

When an employee is injured on the job, **AND REQUIRES MEDICAL ATTENTION**, the following must occur:

- Employee must report the accident to his/her supervisor immediately. Complete the ***Employee's Report*** (attached) and submit to supervisor.

- Supervisor must provide employee with a ***Release for Work Authorization*** form. (Attached)

- Supervisor must complete the ***Supervisor's Report*** (attached) and send it to the District Office ***within 24 hours.***

- Employee must obtain the ***State Accident Form*** from the doctor or hospital. It will be completed by the doctor or hospital and mailed to the state; the state will mail our portion to us for completion.

- Employee must provide the supervisor with a completed ***Release for Work Authorization*** form (attached) **BEFORE** returning to the job. If light duty is contemplated, the supervisor must discuss the light duty proposal with the Superintendent before signing the form. If the employee is released for work with no restrictions, this form must be signed by the medical care provider (doctor, etc.), the employee, and the employee's supervisor.

- Return the ***Release for Work Authorization*** form to the District office ***within 24 hours.***

MERIDIAN SCHOOL DISTRICT

Employee's Report of an Accident

(To be filled out for all occupational injuries or illnesses)

Employee's Name: _____ School: _____

Job Title: _____

Exact time of injury: _____ Date of injury: _____

Location where injury occurred: _____

Name of person to whom this incident was reported: _____ Time: _____

Names of witnesses: _____

Summarize what you think happened: _____

_____

_____

_____

_____

What could have been done to avoid this accident?

_____

Explain in detail: What part of your body was injured? Be Specific _____

_____

_____

Is this an original injury or a re-injury? _____

If a re-injury, when and where was previous injury? _____

Would you be willing to perform light-duty work during your recovery?_____

Date and time you sought medical attention: _____

Whom did you see? _____ Office/hospital _____

Employee Signature: _____ Date: _____

Date employer received report: _____

Note: Washington Administrative Code number is 296-24-025 (6) states: Employee's responsibility:
"Employees shall make a prompt report to their immediate supervisor of each industrial injury."

SUPERVISOR'S REPORT – OCCUPATIONAL INJURY – ILLNESS

Injured Employee

Name:_____ SS# _____

Date of accident, illness or near miss _____ Date of Report _____

Time of accident, illness or near miss ☐ am ☐ pm. Exact location of accident, near miss, or situation causing illness _____

Describe accident, near miss, or situation contributing to illness. Include the machine, equipment, object, or substance involved. Give all details. Use the reverse side if necessary. Attach all other facts, photographs, drawings/diagrams needed to clarify what happened.

_____

_____

_____Carrying/Lifting _____Pounds

Nature of Injury (Injured Part(s) or Body (Indicate right, left, upper, lower, etc.)

__ sprain or strain	__ fracture	__ head	__ hand	__ leg
__ laceration	__ burn	__ eye	__ arm	__ foot
__ contusion	__ foreign body to eye	__ trunk	__ finger	__ toe
__ back	__ internal	__ neck	__ wrist	__ knee
__ other (explain)				

Nature of job-related illness: (Be specific) _____

_____

In your opinion, was the accident caused in any way by someone not employed by the Meridian School District? ☐ Yes ☐ No If yes, please provide the complete name, address, telephone number and employer of the person.

_____

_____

Cause: Mark Basic Cause and any contributing cause:

__ inadequately guarded
__ unguarded
__ defective tools, equipment or substance
__ unsafe design or construction
__ hazardous arrangement
__ unsafe illumination
__ unsafe clothing
__ insufficient instruction
__ operating without authority
__ operating unsafe speed
__ making safety devices inoperative
__ using unsafe equipment or using equipment unsafely
__ unsafe, loading, placing mixing
__ working on moving or dangerous equipment
__ distraction, teasing, horseplay
__ failure to use protective devices

GUIDES TO CORRECTIVE ACTION

Based on the cause checked on the previous page, I am taking the following corrective action:

Unsafe Act	Unsafe Condition	If Supervisor can't handle
__ stop the worker	__ remove	__ recommend to:
__ study the job	__ guard	__ own boss, or
__ instruct (tell, show, try, check)	__ warn	__ Safety Committee, or
__ follow up	__ supervisory	__ Maintenance Department, or
__ enforce	__ other	__ follow-up

What I am actually doing to prevent similar injuries, near misses or illness_____

_____

_____

What further recommendations: _____

_____

_____

_____ _____

Worker Signature Date

_____ _____

Supervisor Date

_____ _____

Department Director Date

MERIDIAN SCHOOL DISTRICT NO. 505
214 W. Laurel Road
Bellingham, WA 98226
360 398-7111

PLEASE RETURN THIS FORM AS SOON AS POSSIBLE TO THE ABOVE ADDRESS

RELEASE FOR WORK AUTHORIZATION

Employee's Name	Building	Job Title	Date of Injury or Illness

PHYSICIAN'S FINDINGS AND RECOMMENDATIONS

NATURE OF INJURY OR ILLNESS _____
_____

IS EMPLOYEE AUTHORIZED TO RETURN TO WORK?

____ Yes, with no restrictions. Date authorized to return: _____

____ Yes, with the following medical or physical limitations: _____

_____

Anticipated date restrictions may be removed? _____

IS FURTHER TREATMENT NECESSARY?

____ No.
____ Yes. If referral is anticipated, please indicate physician or clinic employee is referred to:
_____

IS THE INJURED EMPLOYEE'S TIME LOSS THE DIRECT RESULT OF THE DISABILITY?

____ No.
____ Yes. Estimated number of disabling days: _____

Signature of Physician	Phone Number	Date

EMPLOYER OFFICE USE ONLY

Return to work authorized? _____ No _____ Yes Date authorized to return? _____

Authorized by _____ Date _____ Claim Number _____

_____ _____
Employee's Signature and Date Supervisor's Signature and Date