WORKERS COMPENSATION – INJURY FORM POLK SCHOOL DISTRICT

LOCATION	ADDRESS	

Injured Employee Information

Name		Job Title		Employee ID No. / Badge No.
Work Phone	Home Phone	Cell Phone	Date of Birth / /	SSN

Injury Data

Date of Accident / /	Time of Accident AM PM	Claim No.	NO Injury ☐ (near miss incident)

Injury (cut, broken bone, amputation, burn, etc.) and body part(s) affected
First Aid given by
Transported to (clinic, hospital, etc.)
Treatment medical report on file ☐
Past record of treatment for a similar condition? on file with medical report ☐

Accident Description

Who was involved in the accident?
Events leading up to accident, in sequence:
Exact step or part of job being done?
What occurred:

Witnesses

Who witnessed? (Visitors, general public or bystander, employees from other trades, etc.) **Provide a Witness Statement**

Name	Phone (work or home)	Cell phone	
Name	Phone (work or home)	Cell phone	
Name	Phone (work or home)	Cell phone	

Employee Signature

Signature	Date	Time

Employee Guidelines for Workers' Compensation Accidents

The information included in this packet will become important to you in the event that you seek medical attention or lose time from work due to a work-related injury or illness. The following provides a brief description of the documents included in this packet and how they are to be used:

Report of Work-Related Injury
This form should be completed by the injured employee, if able to do so, or their supervisor and forward to Human Resources.

Procedures:

- Report the accident immediately to your supervisor no matter how insignificant it may seem. Give your supervisor all information regarding the accident so he or she can notify the appropriate personnel.

- If the injury necessitates medical attention, you need to select a doctor from the "Panel of Physicians". The "Panel of Physicians" and "Bill of Rights for Injured Employees" are posted at each facility within Polk School District. In case of an emergency, you may seek medical treatment from any doctor/emergency facility until the immediate emergency is over. However, any additional medical treatment you receive must be provided by a doctor on the "Panel of Physicians".

- When you arrive at the doctor's office or the hospital let the nurse know that **Berkshire Hathaway** administers your worker's compensation program.

- Once **Berkshire Hathaway** receives your injury report, your claim will be assigned to an adjuster. The adjuster will complete an investigation and advise you with regard to the status of your claim. If the investigation concludes that your injury meets the criteria established by state law, you will receive all benefits to which you are entitled under the Workers' Compensation Act. If the adjuster's investigation discloses a non-covered injury, you will be notified in writing of the denial.

- If you are losing time from work, stay in contact with your claim's adjuster. He or she will guide you through the rehabilitation process and help you return to work as soon as possible.

- If you have questions regarding your workers compensation coverage, contact the Human Resources at (770) 748- 3821 or **Berkshire Hathaway** at (800) 661-6029 for additional information.

Claim Reporting Information

Berkshire Hathaway

P.O. Box 881716

San Francisco, CA 94188

SUPERVISORS' REPORT

Preliminary Report ☐ Final Report ☐

Supervisor Name	Supervisor Work Phone	Employee ID No. / Badge No.
Loss Severity Potential 1 (minor) 2 3 4 5 (major)	Probable Recurrence Rate 1 (rare) 2 3 4 5 (frequent)	

Photos / description of damaged property or equipment Photos electronically on file ☐
(attach on separate sheet if necessary)

Blood borne Pathogens Record (Enter Name of person who had contact, and name of Source Person of the blood / body fluid)

Name	Source person	Tested (date)	Treated (date)	Counseled (date)
Name	Source person	Tested (date)	Treated (date)	Counseled (date)
Name	Source person	Tested (date)	Treated (date)	Counseled (date)

Root Cause/ Accident Findings (√ any that apply)

Unsafe vehicle operation ☐	Adverse weather / Extreme temperatures ☐	Physical or mental Limitation ☐	Inadequate training ☐
Horseplay ☐	Poor road conditions ☐	Pre-existing physical condition ☐	Lack of proper supervision ☐
Disabling safety devices/guards ☐	Inadequate guards or protection ☐	New impairment or condition ☐	Inadequate safety procedures ☐
Failure to lockout ☐	Defective tools, machine, equipment or vehicle ☐	Drugs or alcohol ☐	Inadequate job planning ☐
Operating without authority ☐	Hazardous atmosphere (gas, dust, fumes, vapors) ☐	Learning disability ☐	Safety plan / job procedures not followed ☐
PPE not used ☐	Hazardous chemical /substance ☐	Employee insubordination ☐	Improper layout or design of work area ☐
Inadequate machine maintenance ☐	Inadequate warning system ☐	Employee dishonesty ☐	Inadequate medical monitoring ☐
Improper material handling ☐	Fire or explosion hazards ☐	Unaware of hazards ☐	☐
Taking unsafe position ☐	Improper material storage ☐	Lack of skill/knowledge ☐	☐
Employee unsafe behavior or Employee Violence ☐	Excessive noise ☐	Acted to avoid discomfort ☐	☐
Unsafe or Violent act of non-employee ☐	Poor illumination/limited visibility ☐	Tried to avoid extra effort ☐	☐
Poor housekeeping ☐	In a Hurry ☐	Tried to gain or save time ☐	☐

What contributed most directly to accident/incident?

What are the basic/fundamental reasons for the existence of the contributing factor(s)?

Preventing Recurrence: Employee Retraining, and Correction of Hazards

Action	Emp. Initials	Supv. Initials	Date Completed
Action	Emp. Initials	Supv. Initials	Date Completed
Action	Emp. Initials	Supv. Initials	Date Completed
Action	Emp. Initials	Supv. Initials	Date Completed
Action	Emp. Initials	Supv. Initials	Date Completed

WITNESS STATEMENT

Form provided by (Name of Employee)	Work Phone	Email
Date form was provided	Date Returned	(Office Use Only)

Witness Information

Name	cell phone	work phone	home phone	email
Name	cell phone	work phone	home phone	email

Hazards Observed (√ any that apply)

Unsafe vehicle operation		Adverse weather / Extreme temperatures	
Hazardous atmosphere (gas, dust, fumes, vapors)		Poor road conditions	
Hazardous chemical /substance		Fire or explosion hazards	
Drugs or alcohol		Poor illumination / limited visibility	
Horseplay		Excessive noise	

Photos taken by witness: (you may also draw or diagram your observations here) Photos were emailed

Accident Description (what happened, in your own words)

Who did you speak to at the accident? (list names below)

Signature	Date
Signature	Date

PROVIDED BY

Berkshire Hathaway HOMESTATE COMPANIES

PROMOTING WORKER SAFETY