PENN-TRAFFORD SCHOOL DISTRICT
WORK RELATED INCIDENT REPORT

****ALL CLAIMS MUST BE REPORTED WITHIN 24 HOURS****

Section One: Employee and Incident Information – ALL FIELDS MUST BE COMPLETED

School District Name (No Abbreviations):	SCHOOL DISTRICT ADDRESS:	County:
Penn-Trafford School District	P.O. Box 530, Harrison City, PA 15636	Westmoreland

Employee Name (last, first, middle initial)	Home Phone:	Gender: M F	Martial Status: M S

Home address (street, city, state, zip):	County:

SS#:	Date of Birth:	Date of Incident:	Time of Incident:	Date Reported:	To Whom Reported:

Location of Incident (building, room, etc.):	Type of injury (cut, sprain, etc.):

Injured Body Part:	Cause of injury (machine, tool, etc.):

Employee's job title:	Date of Hire:	Hours worked per week:	Time Shift starts:

Description of incident: (please describe in detail what happened):

Name of Supervisor: _____

Section Two: Medical Authorization

I, the undersigned, hereby authorize any medical care provider who has treated me, or any hospital to which I have been admitted, to furnish to any authorized representative of School Claims Service, LLC, any and all information which may be requested regarding my physical condition, treatment or disease, and if necessary, to allow them or any physician appointed by them to review any X-rays or records, regarding my physical condition or treatment.

Employee's signature: _____ **Date:** _____

****CLAIMS MUST BE REPORTED TO HUMAN RESOURCES WITHIN 24 HOURS OF INJURY****

Section Three: For Use of School District Workers' Compensation Coordinator – ONLY

Type of claim: ☐ **Notice Only (no Medical Treatment)** ☐ **Medical Only** ☐ **Lost time/Last date worked** _____/_____/_____

Name of W/C Coordinator: Ramona L. Pope **Phone: 724-744-4496**

Section Four: Medical Treatment

Type of Injury: _____ ☐ **New** ☐ **Other (describe):** _____
Treatment/first aid: _____
Diagnosis: _____

Disposition: _____ ☐ **Return to work without limitations**
☐ **Return to work with noted limitations (describe):** _____
☐ **May return to work on** _____/_____/_____
☐ **Follow up appointment with:** _____ **On:** _____/_____/_____
Signature of medical/first aid provider: _____ **Date** _____/_____/_____
Address: _____

Workers' Comp Coordinator ONLY – FAX TO SCHOOL CLAIMS SERVICE, LLC WITHIN 24 HOURS OF INJURY

UPMC Work Partners
Claims Management Services
PO Box 2971
Pittsburgh, PA 15230
Tel: (800) 633-1197 Fax: (412) 454-8717

INCIDENT INVESTIGATION REPORT

(To be conducted by the supervisor with the employee)

Note: The information provided in this report will be used to promote a safer working environment for all employees by identifying unsafe work practices or conditions of this report will not be used to criticize or penalize employees injured on the job.

PLEASE PRINT

Employee Name: _____ Date of Injury: _____

Employer Name: _____

1. Describe the basic cause(s) of the incident (what specific factor(s) caused the incident – what was the employee doing, how was the activity being carried out and what machinery, equipment, tools, or objects were involved?:

2. Would you describe this incident being the result of ☐ work practice ☐ work environment ☐ both
3. Was personal protection equipment or guards provided for this activity ? ☐ Yes ☐ No
4. Was the personal protection equipment or guards being used at this time? ☐ Yes ☐ No
5. Should personal protection equipment or guards be provided for this activity? ☐ Yes ☐ No
6. Are there safety rules that apply to this activity? ☐ Yes ☐ No
7. How could this incident have been prevented?

8. Describe the resulting injuries:

9. Witnesses:

Name	Phone (day)	Phone (evening)
_____	_____	_____
_____	_____	_____
_____	_____	_____

10. Explain in detail what actions could be taken to correct the unsafe act or condition.

11. Who is responsible for implementing the corrective action and when do you anticipate it will be accomplished?

Supervisor Signature _____ Date _____