WORKERS COMP INJURY REPORTING - *IF YOU ARE INJURED AT WORK:*

ATTENTION: NEW PROCEDURE - JULY 2020!!!
CALL THE NEW INJURY HOTLINE TO REPORT THE INCIDENT!!
855-675-3501

Obtain an Injury Report packet from the Building Secretary or from the district website.
You are required to complete a report whether or not you seek medical attention

If medical attention is needed (other than an emergency):

Call Unity Point Trinity Occupational Medicine @ 563-262-4120 to make an appointment.

Unity Point Trinity Occupational Medicine
1616 Cedar Street (Upper Level), Muscatine, Iowa 52761
Hours 8:00 am to 5:00 pm, Monday – Friday

For treatment that cannot wait until clinic hours, please call-
Unity Point Trinity Hospital Express Care
1518 Mulberry Avenue, Muscatine, Iowa 52761
Hours 8:30am – 8pm, M – F, 9am – 4:30pm, Sat./Sun. 563-264-9508
OR
Emergency Room (if necessary) 563-264-9240

- ***PLEASE NOTE:*** **Do NOT call your own medical provider – workers comp is not obligated to pay if you call your own provider.**

Employee: Fill out the **Employee Injury Report** (page 2) **completely**, being specific about what the injury is and what caused it. (Saying you are hurt is not specific enough).

- Be sure to complete the **Treatment Information** box.
- **You and your Supervisor/Designee must sign this page.**

Supervisor/Designee: Complete the **Employer's Report of Employee Injury** (page 3) with as much information as you know about the incident.

- **Please be sure to mark the Medical Care Section.**
- **Sign and date the report.**

Fax completed reports to the Administration Center @ 563-263-7729 to the attention of Marsha Shingledecker.

EMPLOYEE INJURY REPORT
Muscatine Community School District

Please complete ALL information & return this form to Marsha Shingledecker at the Admininstration Center **within 24 hours of the incident. You may fax it to (563) 263-7729.**

Name of Employee: _____

Job Title: _____ **Date of Birth:** ____/____/____

Address of Employee: _____ **Phone:** _____

Marital Status: __Single __Married __Divorced __Widowed

Date of Injury: _____/_____/_____ **Time of Injury:** _____am / pm

Date Employer Notified: _____/____/_____

Time Workday Started: _____am / pm **Number of hrs per day/shift usually worked:** _____

Location name or address where injury occurred:
Describe the nature of the injury. (Ex. Bruise, cut, sprain, etc.):
Part(s) of the body directly affected by injury. (Ex. Left hand, right arm):
Describe the events that caused the injury:
Name the object or substance that directly injured the employee:
Specific activity employee was engaged in when injury occurred:

Witness Name(s) (if any): _____ **Witness Phone:** _____

Employee's Authorization to Release the Following:
Medical Records ____Yes ____No / **Social Security #** ____Yes ____No

TREATMENT INFORMATION - PLEASE CHECK ONE:

____No medical treatment ____Minor/On-site treatment ____Clinic or Hospital Visit

If medical treatment, circle one: Unity Point Trinity Occupational Medicine or local ER

X Employee's Signature: _____ **Date** _____

X Supervisor's Signature: _____ **Date** _____

In case of an emergency, call an ambulance or take the employee to the emergency room! Notify the Administration Center as soon as possible.

EMPLOYER'S REPORT OF EMPLOYEE INJURY

(Please complete to the best of your knowledge)

NAME OF EMPLOYEE_____ DEPT._____

DATE OF INCIDENT_____ TIME_____ JOB TITLE_____

Please answer the questions below. Your answers may help us prevent future occurrences.

		YES	NO	UNKNOWN
1	Did injured party report the incident to someone immediately?			
2	Was injured person properly instructed in safe and efficient methods?			
3	Did you witness the incident?			
4	Did you attempt to verify whether this incident could have actually taken place?			
5	Did injured person violate any instructions?			
6	Was necessary protective equipment worn? (if applicable)			
7	Did poor housekeeping contribute to the injury?			
8	Did horseplay cause the injury?			
9	Was it caused by something which needed repairs?			
10	Was it caused by an unsafe act? If yes, describe below.			

DESCRIBE THE INCIDENT IN AS MUCH DETAIL AS YOU KNOW: _____

WITNESS NAMES (IF ANY)_____

UNSAFE ACTS (IF ANY)_____

CORRECTIVE ACTIONS TAKEN (IF ANY) _____

REMEDIES (WHAT SHOULD BE DONE TO PREVENT OTHER INJURIES LIKE THIS?)_____

MEDICAL CARE (PLEASE COMPLETE THIS SECTION!)

IS EMPLOYEE GOING TO THE DOCTOR OR HOSPITAL? YES ☐ NO ☐ **IF YES**, CIRCLE ONE OF THE FOLLOWING:

UNITY POINT TRINITY OCCUPATIONAL MEDICINE OR ER DATE OF INITIAL VISIT_____

DO YOU QUESTION THIS CLAIM ? YES ☐ NO ☐ If yes, reason(s)why_____

REPORT SUBMITTED BY X_____ **DATE**_____

(SIGNATURE & DATE REQUIRED!!!)