Unified Government Human Resources Guide

Effective 05-01-2019

INJURY REPORT

ATTENTION: The injured employee and their supervisor should fill out the first two pages of this form. Send one copy of this form to Human Resources at workcomp@wycokck.org by ***the next business day following the incident*** and retain one copy for department files. For questions or immediate medical authorization call (913) 573-5640.

Department/Division:		Today's Date:	
Department/Division Contact Person:		Phone:	
Employee Name:		Employee Phone:	
Job Title:		Employee ID:	
Employee Schedule: (Mark days worked)	☐Su ☐M ☐T ☐W ☐Th ☐F ☐Sa	Hours:	☐a.m. ☐p.m. to ☐a.m ☐p.m
Home Address:		City/State:	Zip:
Date of Injury:		Time:	☐ a.m. ☐ p.m.
Date Reported:		Reported to:	
Exact location of accident:		Was this Unified Government property?	☐ yes ☐ no
Describe in detail how the accident happened:			
Substance or object that directly caused injury:			
Describe in detail nature and extent of injury:			

Part of body affected:

☐ eye(s) ☐ head ☐ ear(s) ☐ nose ☐ back ☐ arm(s) ☐ hand(s) ☐ elbow(s) ☐ finger(s) ☐ leg(s) ☐ foot ☐ toe(s)
☐ knee(s) ☐ shoulder(s) ☐ facial bones ☐ ankle(s) ☐ other (please specify):____________________

Injury type:

☐ amputation	☐ concussion	☐ foreign object	☐ repetitive stress (incl. carpal tunnel)
☐ bloodborne pathogen	☐ contusion	☐ fracture	☐ skin irritation (incl. poison ivy)
☐ bite/sting	☐ disease	☐ laceration	☐ sprain/strain
☐ burn	☐ dislocation	☐ puncture	☐ other (specify) ____________

Was medical treatment required? ☐ yes ☐ no If yes, where treated: ☐First Aid ☐Clinic ☐Hospital/ER ☐Other

Describe "other," if checked: ____________________

Name/address of Clinic/Hospital/ER: ____________________

Witnesses: (If more than two, identify on separate page. Please attach witness statements.)

Name: ______________________________ Phone: ________________ Employee ☐ yes ☐ no

Address: ____________________________ City/State: ________________ Zip __________

Name: ______________________________ Phone: ________________ Employee ☐ yes ☐ no

Address: ____________________________ City/State: ________________ Zip __________

Employee Work Status	
Please attach a copy of the employee's work status or doctor notes and return with the completed injury report.	
The above employee is:	
☐	Working at his/her regular duty (no restrictions).
☐	Working at light or modified duty (can provide work within the given restrictions). If checked, please state location/task provided:
☐	Off work because of temporary total disability (no work available within restrictions or employee taken off of work by authorized medical provider). If checked, please enter date Injury Leave began:

Employee Signature:______________________________**Date:**________________

Employee Print:______________________________

Supervisor Signature:______________________________**Date:**________________

Supervisor Print:______________________________

SUPERVISOR REVIEW AND ACTION

ATTENTION: Supervisors complete the following section. **Employee:**____________________ **DOI:**____________

How was the employee acting when the incident occurred? Select all that apply.

☐ Apparently normal ☐ In a hurry/rushing ☐ Stressed ☐ Impaired
☐ Fatigued/Fell asleep ☐ Frustrated ☐ Complacent ☐ Other: _____

Environment
Which environmental conditions played a role in the accident? Select all that apply.
☐ Inadequate lighting ☐ Poor housekeeping ☐ Lack of warning signs or devices
☐ Unstable terrain ☐ Noise ☐ Other: _____
☐ Weather/Temperature ☐ Poor visibility ☐ N/A

Cause of injury
What was the primary cause of the injury?
☐ Struck against/by ☐ Caught in/between ☐ Improper body mechanics/Lifting
☐ Contact with ☐ Over exertion ☐ Repetitive stress injury/Carpal tunnel
☐ Slip/Trip/ Fall ☐ Other individual ☐ Other: _____

Equipment
☐ Unfamiliar with new equipment ☐ Defective equipment ☐ Wrong equipment used
☐ Unguarded equipment ☐ Equipment availability ☐ No equipment involved

Training
Is the employee familiar with the job task and has the employee been trained on how to perform the task?

☐ Not familiar with task. No training. ☐ Formal training occurred but forgotten by employee.
☐ Familiar with task; no formal training in place. ☐ Formal training but failed to follow proper procedure.

Prevention
What actions are planned to help prevent a reoccurrence of this type of accident?

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Supervisor Signature:__________________________________**Date:**__________________

Division Head Signature:______________________________**Date:**__________________

Received by Human Resources: _________________________**Date:**__________________