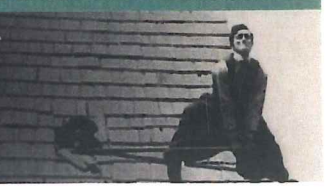
IN CASE OF WORKPLACE INJURY

ACCION a seguir en caso de un accidente en el trabajo

COMPANY NURSE™
Because Accidents Happen™



AVAILABLE 24 HOURS A DAY

1-877-518-6702

Employer Name (Nombre De Compania)	Search Code (Código Del Búqueda)
Biggs Unified School District	NVS52

1. **Injured worker notifies supervisor.**
   Empleado lesionado notifica a su supervisor.

2. **Supervisor/Injured worker immediately calls injury hotline.**
   Supervisor / Empleado lesionado llama inmediatamente a la línea de enfermeros/as.

3. **Company Nurse gathers information over the phone and helps injured worker access appropriate medical treatment.**
   Profesional Médico obtiene información por teléfono y asiste al empleado lesionado en localizar el tratamiento médico adecuado.

NOTICE TO EMPLOYER/SUPERVISOR: Please post copies of this poster in multiple locations within your worksite. If the injury is non-life threatening, please call Company Nurse prior to seeking treatment. Minor injuries should be reported prior to leaving the job site, when possible.

BIGGS UNIFIED SCHOOL DISTRICT
300 B STREET
BIGGS, CA 95917

PAYROLL
(530)868-1281 E 259
FAX (530)868-1615

Employee Incident Information and Reporting

INCASE OF WORKPLACE INJURY:
ACCION A SEGUIR EN CASO DE UN ACCIDENTE EN EL TABAJO

COMPANY NURSE:

1. Injured worker notifies supervisor
Empleado lesionado notifica a su supervisor

2. Supervisor/injured worker immediately calls injury hotline.
Supervisor/empleado lesionado llama inmediatamente a la linea de enfermeros/as.

IN CASE OF INJURY, CALL
EN CASO DE UN ACCIDENTE, LLAMAR A:
877-518-6702

EMPLOYER NAME (NOMBRE DE COMPANIA)
BIGGS USD

SEARCH CODE (CODIGO DE BUSQUEDA)
NVS52

Employee Incident Report:

EMPLOYEE INFORMATION

Name: _____ ID #: _____

Job Title: _____ Department: _____

Work Phone #: _____ Time you began work on the day of the incident: _____

What hours do you normally work? (please indicate a time frame (i.e.: 8:00-4:30) _____

INCIDENT INFORMATION

DATE OF INCIDENT: _____ **TIME OF INCIDENT:** _____

DATE REPORTED: _____ TIME REPORTED: _____

Incident initially reported to: _____ Phone #: _____

Were you performing your normal occupation at the time of the incident? ☐ Yes ☐ No

If no, please explain: _____

Location where incident occurred (**please include physical address**): _____

Were there any witnesses? ☐ Yes ☐ No

If yes, list names and contact numbers: _____

Were there any safety hazards? ☐ Yes ☐ No If yes, please explain: _____

How did the incident happen? Describe specific activity you were performing at the time incident occurred, including, tools, equipment, or materials used:

Describe the part of body affected & **how** affected (please be specific with how your injury is affecting you, i.e.: sprain, fracture, contusion, etc.)

Have you injured this part of your body previously? ☐ Yes ☐ No

If yes, please explain: _____

Did you leave work following the incident? ☐ No ☐ Yes

If yes, what date and time did you return? Date: _____ Time: _____

Have you previously filed an injury claim? ☐ No ☐ Yes Date/Details: _____

IMPORTANT INFORMATION

Do you require medical attention now? ☐ Yes ☐ No
If yes, please indicate the name of the approved facility you will be using: _____

Please sign and date below and give this form to your Supervisor or site office ***immediately.*** Unless this is a true medical emergency, you may not seek treatment before consulting with the Payroll Department.

If medical attention is not needed now for this incident, but is necessary at a later date, you **MUST** contact the Business Office at 530-868-1281 ext. 259 or ext. 252

Failure to report occupational injuries in a timely manner may result in a delay of any possible workers' compensation benefits while BUSD and the insurance carrier investigate your claim.

**Any person who makes or causes to be made any knowingly false or fraudulent material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Employee signature: _____ Date signed: _____

Name of person completing this form if employee is unable to do so: _____
Signature: _____ Date signed: _____
Job Title: _____ Phone #: _____

***If you are involved in a Motor Vehicle Accident you will also need to fill out an INS-8 form and return it with this form.**
Please indicate if you have filled out the INS-8 form: ☐ Yes ☐ N/A

SUPERVISOR INFORMATION

I have reviewed the information detailed above and have recommended/implemented the following actions to prevent similar incident in the future:

_____
_____
_____
_____

Reviewer's signature: _____ Date signed: _____
Job Title: _____ Phone #: _____

FAX THIS COMPLETED REPORT *IMMEDIATELY* TO (530) 868-1615

DO NOT DELAY IN REPORTING INJURIES TO THE PAYROLL DEPARTMENT
**If Supervisor is initially unavailable to sign, fax form without obtaining his/her signature.
Put original in mail/courier to PAYROLL after securing all signatures.