

**NATOMAS UNIFIED SCHOOL DISTRICT  
EMPLOYEE INCIDENT REPORT**

Employee Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

\_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Job Title \_\_\_\_\_ School Site \_\_\_\_\_

Date of injury \_\_\_\_\_ Time of day \_\_\_\_\_

Where did the accident or exposure occur? *(Number and street and/or building)*

\_\_\_\_\_

What was the employee doing when injured? *(Be specific: identify tools, equipment, and materials being used).*

\_\_\_\_\_

\_\_\_\_\_

How did the accident or exposure occur? *(Describe fully the events that resulted in injury or occupational disease. Tell what happened and how it happened.)*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Object or substance that directly injured employee *(e.g. the machine employee struck against or which struck him/her; the vapor or poison inhaled or swallowed; the chemical that irritated his/her skin):*

\_\_\_\_\_

Describe the injury or illness *(e.g. cut, strain, fracture, rash, etc.):*

\_\_\_\_\_

Part of the body affected (e.g., back, left wrist, right eye, etc.)

Did employee lose at least one full day of work? Yes \_\_\_\_ No \_\_\_\_

Witness names and contact information:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

*It is unlawful to: (a) present or cause to be presented any false or fraudulent claim for the payment of a loss under a contract of insurance, (b) prepare, make or subscribe any writing with intent to present or use the same or allow it to be presented or used in support of any such claim. Every person who violates any provision of this section is punishable by imprisonment in the state prison not exceeding three years or by fine not exceeding one thousand dollars or by both.*

**Signature of person filling out form**                      **Date**

**Supervisor's Signature**                                      **Date**

If the employee is requesting medical treatment, confirm the date the injury was reported to the EIN (1-877-742-3467)

*Date Reported:*

If the employee is NOT requesting workers' compensation benefits, sign here to acknowledge:

*At this time, I am not seeking workers' compensation benefits, i.e. medical treatment, temporary disability payments, etc. I will immediately advise my supervisor and the Early Intervention Nurse (EIN) if I later wish to place a claim for benefits as a result of this incident.*

*Signed By:* \_\_\_\_\_ *Date:* \_\_\_\_\_