INJURY REPORTING

Step-by-step Instructions for reporting work related injuries at your center.

1. Complete the First Report of Injury Form

Every employee is to report any work-related injury or illness to his/her supervisor immediately. Upon being notified of the injury or illness, the supervisor should complete a "**First Report of Injury or Illness**" form. The supervisor should document the names of any co-workers who may have witnessed the incident.

Failure to report an injury/illness may result in a delay or forfeiture of rights available from workers' compensation.

2. Contact Human Resources

Human Resources will then report the injury to LWCC. The injured employee may sometimes be required to participate in the initial telephone call to LWCC with Human Resources either in the Human Resources office or via conference call.

ALL REPORTING WILL BE DONE BY HUMAN RESOURCES

Injuries or RPO's **should not be** individually reported to LWCC, unless specifically directed by HR or the Executive Director

3. Initial Medical Treatment

Human Resources will then give a required authorization for treatment for Medical Treatment for work-related injury, if needed.

For minor injuries requiring only first aid, no authorization for treatment is needed. A Drug and Alcohol Test will be required for all injuries resulting in medical treatment (except first aid) or property damage.

4. Gather Statements

Have the injured worker complete the **"Employee Statement of Injury/Illness."** This form must be completed and signed in writing by the injured employee. If possible, the form should be completed the same day as the injury/accident.

Have any and all witnesses complete the **"Witness Statement of Injury/Illness."** This form must be completed and signed in writing by any all witnesses.

5. Investigation

ASAP complete the **"Supervisor Accident Investigation & Report of Findings."** This form must be completed and signed in writing by the injured workers' supervisor. TIP: Take pictures and save video surveillance.

*******Emergencies*******

If immediate medical assistance is required, 911 should be called. The employee's supervisor should notify Human Resources of the injury as soon as possible and submit the Report of Injury form.

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)

Regina Coeli Child Development Center
22476 Highway 190
Robert, LA 70455

CARRIER/ADMINISTRATOR CLAIM NUMBER | OSHA LOG NUMBER | REPORT PURPOSE CODE

JURISDICTION | JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) | LOCATION #

INDUSTRY CODE | EMPLOYER FEIN | PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)

LWCC
PO Box 98052
Baton Rouge, LA 70898
800-395-0303

POLICY PERIOD

TO

CHECK IF APPROPRIATE

SELF INSURANCE ☐

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

CARRIER FEIN | POLICY/SELF-INSURED NUMBER: 22373-B | ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER: Gillis, Ellis & Baker, Inc.

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE) | DATE OF BIRTH | SOCIAL SECURITY NUMBER | DATE HIRED | STATE OF HIRE

ADDRESS (INCL ZIP)

SEX: ☐ MALE ☐ FEMALE ☐ UNKNOWN

MARITAL STATUS: ☐ UNMARRIED SINGLE/DIVORCED ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

PHONE | # OF DEPENDENTS | NCCI CLASS CODE

RATE PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER: | DAYS WORKED/WEEK | FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE? ☐ YES ☐ YES ☐ NO ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM | DATE OF INJURY/ILLNESS | TIME OF OCCURRENCE ( ) CANNOT BE DETERMINED ☐ AM ☐ PM | LAST WORK DATE | DATE EMPLOYER NOTIFIED | DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER | TYPE OF INJURY/ILLNESS | PART OF BODY AFFECTED

DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO | TYPE OF INJURY/ILLNESS CODE | PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK | IF FATAL, GIVE DATE OF DEATH | WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO | WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)

INITIAL TREATMENT
- ☐ NO MEDICAL TREATMENT
- ☐ MINOR: BY EMPLOYER
- ☐ MINOR CLINIC/HOSP
- ☐ EMERGENCY CARE
- ☐ HOSPITALIZED > 24 HOURS
- ☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED | DATE PREPARED | PREPARER'S NAME & TITLE | PHONE NUMBER

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YY format.

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED: (eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

EMPLOYER'S INSTRUCTIONS – cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.

EMPLOYEE STATEMENT OF WORKPLACE INJURY/ILLNESS

I am reporting a: ___ INJURY ___ ILLNESS ___ NEAR MISS

NAME: _____ **POSITION**: _____

SUPERVISOR: _____ **CENTER**: _____

Date of Injury/Illness: _____ Time of Injury/Illness: _____

Have you reported the injury/illness to your supervisor? _____ YES _____ NO

Date and Time You Notified Your Supervisor or the Person in Charge: _____

Names & contact information of witnesses (if any): _____

_____

What parts of your body were injured? If a near miss, how could you have been hurt? _____

_____

_____

Did you see a doctor for your injury / illness? If so, provide the name and number of physician. _____

_____

Have you ever injured or had medical treatment for this part of your body prior to this incident? If so, explain: _____

_____

Where were you when the accident/near miss occurred? _____

_____

What were you doing at the time of the accident/near miss? _____

_____

Describe in detail the events of the accident/near miss, including all things leading up to and following the incident (continue on back if necessary): _____

_____

_____

_____

_____

_____

How could have this accident/near miss been prevented? _____

_____

Employee's Signature: _____

Date of Statement: _____

"PURSUANT TO LSA-RS 23:1208 AND 1208.1 OF THE LOUISIANA WORKERS' COMPENSATION ACT, I UNDERSTAND THAT THE FAILURE TO ANSWER TRUTHFULLY ANY OF THE QUESTIONS BELOW SHALL RESULT IN (1) A FINE OF NOT MORE THAN FIVE HUNDRED DOLLARS OR IMPRISONMENT FOR NOT MORE THAN TWELVE MONTHS, OR BOTH AND (2) A FORFEITURE OF COMPENSATION AND MEDICAL BENEFITS UNDER THE LOUISIANA WORKERS' COMPENSATION ACT."

SUPERVISOR'S ACCIDENT INVESTIGATION & REPORT OF FINDINGS

THIS IS A REPORT OF: ___ Near Miss ___ First Aid Only ___ Med Only ___Lost Time

HAS THE HUMAN RESOURCES DEPT BEEN NOTIFIED? _____ YES _____ NO

If YES, DATE & TIME OF HR NOTIFICATION: _____WHO DID YOU SPEAK TO? _____

Employee's Name:_____ **Date & Time of Injury/Near Miss**:_____

Employee's Position:_____Center:_____

Employee's Contact No.:_____

Employee's Length of Employment: _____ < 3mths _____< 6mths _____<1yr _____>1yr

Date & Time Employee Notified You Or The Person In Charge Of Accident: _____

INJURY INFORMATION

Place an "X" on the line(s) that best describe the body part affected and nature of injury / illness.

____ Head	____ Stomach / Torso	____ Amputation	____ Scratch
____ Neck	____ Internal	____ Asphyxia	____ Radiation
____ Face	____ Back	____ Contagious	____ Hernia
____ Mouth	____ Shoulder	____ Contusion / Bruise	____ Strain
____ Arm (Left)	____ Hand (Left)	____ Cut / Puncture	____ Sprain
____ Arm (Right)	____ Hand (Right)	____ Dermatitis	____ Infection
____ Leg (Left)	____ Foot (Left)	____ Poisoning	____ Fracture
____ Leg (Right)	____ Foot (Right)	____ Electric Shock	____ Hearing
____ Knee (Left)		____ Foreign Body (Eye)	____ Burn
____ Knee (Right)		____ Unconsciousness	

ACCIDENT DESCRIPTION:

Describe fully how the accident/near miss occurred? _____

_____

_____

What was the employee doing prior to the accident/near miss?_____

_____

What was the cause of the accident or near miss?_____

_____

Was the accident or near miss the result of unsafe act(s)? If yes, please explain:_____

_____

Were unsafe condition(s) a factor in the cause of the accident/near miss? If yes, please explain**:** _____

_____

SUPERVISOR'S ACCIDENT INVESTIGATION & REPORT OF FINDINGS

What part of the employee's workday did the accident/near miss occur?

_____ **Entering or Leaving Work** _____ **During Normal Work Activity**

_____ **During Meal/Break** _____ **During Overtime Shift**

_____**During Work Related Travel**

What was the **exact** location of the accident/near miss?_____

Were any unsafe conditions reported or observed prior to the accident? If so, please explain:_____

_____

_____

How could the accident/near miss been prevented?_____

_____

List any and all witness along with contact information (utilize the back of the form if necessary):_____

_____

_____

What is your recommended preventative action?_____

_____

_____

How & when do you plan to implement preventive measures? _____

_____

Please utilize the space below to list any additional comments or information:_____

_____

_____

_____

Supervisors Signature: _____

Date of Report: _____

Reviewed by:_____ **Date of Review:**_____

Signature of Reviewer:_____

Remember to save any video surveillance and/or take pictures of property damage or of scenes of the accident.

******** THIS FORM IS NOT A REPLACEMENT FOR CALLING OR NOTIFYING HUMAN RESOURCES AND/OR THE SAFETY COORDINATOR **********

WITNESS STATEMENT OF WORKPLACE INJURY/ILLNESS/NEAR MISS

I am reporting a: ___ INJURY ___ ILLNESS ___ NEAR MISS

WITNESS NAME: _____

WITNESS ADDRESS: _____

WITNESS CONTACT PHONE #: _____

Did you visibly witness the events of this accident/near miss? ___ YES ___ NO

If employed by RCCDC, has the accident/near miss been reported to the supervisor?
___ YES ___ NO

Date of Injury/Near Miss:_____ Time of Injury:_____

Please list all areas of the body the injured employee stated was injured or in pain:___
_____

What was the employee or employees doing at the time of the accident / near miss? _
_____

Was the injured employee or employees working at the time of the accident/near miss? _____

Where did the accident/near miss occur?_____

Where were you when the accident/near miss occurred? _____
_____

What were you doing at the time of the accident/near miss? _____
_____

Describe in detail the events of the accident/near miss, including all things leading up to and following the incident (continue on back if necessary):_____
_____
_____
_____
_____

To the best of your knowledge, was the employee or employees following safety procedures? _____

Please provide the names of any other witnesses:_____
_____

Witness' Signature: _____
Date of Statement:_____

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