Regina Coeli
Child Development Center
Head Start and Early Head Start

INJURY REPORTING INSTRUCTIONS

Every employee is to report any work-related injury or illness to his/her supervisor immediately. Failure to report an injury/illness may result in a delay or forfeiture of rights available from Workers' Compensation.

1. **Complete the First Report of Injury form**
   - Highlighted areas need to be completed in their entirety.

2. **Contact Business Operations immediately**
   - Business Operations will report the injury to LWCC, if necessary. The injured employee may sometimes be required to participate in the initial telephone call to LWCC with Business Operations.

3. **Initial Medical Treatment**
   - Business Operations will then give a required authorization for medical treatment for work-related injury, if necessary.
   - For minor injuries requiring basic first aid only, no authorization for treatment is needed.
   - A Drug & Alcohol test will be required for all injuries resulting in medical treatment or property damage (with the exception to first aid). The employee has 4 hours from the time of the accident to produce a specimen.

4. **Gather Statements**
   - The injured employee needs to complete the **Employee Statement of Injury/Illness** form. It must be completed in its entirety and signed by the employee. If possible, the form should be completed the same day as the injury/accident.
   - Any and all witnesses need to complete the **Witness Statement of Injury/Illness** form. It must be completed in its entirety and signed by the witness.

5. **Investigation**
   - Supervisors need to complete the **Supervisor Accident Investigation** form immediately. It must be completed in its entirety and signed by the injured worker's supervisor.
   - Take pictures of the scene of the accident and any related information

Emergencies

IF IMMEDIATE MEDICAL ASSISTANCE IS REQUIRED, 911 SHOULD BE CALLED. THE EMPLOYEE'S SUPERVISOR SHOULD NOTIFY BUSINESS OPERATIONS IMMEDIATELY AND SUBMIT THE FIRST REPORT OF INJURY FORM.

REVISED 7.26.24

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCLUDING 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 # (IF AVAILABLE)

INDUSTRY CODE | EMPLOYER FEIN | PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE #)
LWCC
PO Box 98052
Baton Rouge, LA 70898

POLICY PERIOD
6/1/2024 TO 5/31/2025

CHECK IF APPROPRIATE:
SELF-INSURANCE ☐

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE #)

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

AGENT NAME & CODE NUMBER
POWELL & ASSOCIATES

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE) | DATE OF BIRTH | SOCIAL SEC. # (IF THERE IS ONE) | DATE HIRED | STATE OF HIRE: LOUISIANA

ADDRESS (INCLUDING 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? ☐ YES ☐ NO

DID SALARY CONTINUE? ☐ YES ☐ 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 RETURNED 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/HOSPITAL
☐ EMERGENCY CARE
☐ HOSPITALIZED > 24 HOURS
☐ FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED

OTHER

WITNESS(ES) NAME(S) & PHONE #(S)

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

Employee Statement of Workplace Injury/Illness

I AM REPORTING AN: INJURY☐ ILLNESS☐ NEAR MISS☐

Name:_____ **Position:**_____

Supervisor:_____ **Center:** _____

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

Have you reported the injury/illness to your supervisor? **Yes☐** **No☐**

Names & Contact Information of Witnesses (if any):_____

_____

What parts of your body were injured?_____

Do you need to seek medical attention? **Yes☐** **No☐**

If no, please initial that you understand that you have a right to medical care and are choosing not to seek care at this time, if you need medical care in the future please notify your supervisor immediately _____

Have you ever injured or had medical treatment for this part of your body prior to this incident? **Yes☐** **No☐**

If yes, please 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:

_____

_____

_____

_____

_____

I certify that all above information is true and accurate to the best of my knowledge:

_____ _____

Employee Signature **Date**

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

FORM REVISED 7.26.24

Supervisor Accident Investigation & Report of Findings

THIS IS A REPORT OF: NEAR MISS☐ FIRST AID ONLY☐ MEDICAL ONLY☐ LOST TIME☐

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

Has the Human Resources Department been notified? Yes☐ No☐

Employee's Name:_____ Date & Time of Incident:_____

Employee's Position:_____ Center:_____

Employee's Address:_____

Employee's Contact Number:_____

Employee's Length of Employment: 0-3 Months☐ 4-6 Months☐ 7-12 Months☐ 1 year +☐

INJURY INFORMATION

Please check the appropriate box that describes the body part affected by the nature of the injury/illness.

	Head
	Neck
	Face
	Mouth
	Arm (Left)
	Arm (Right)
	Leg (Left)
	Leg (Right)
	Knee (Left)
	Knee (Right)

	Stomach/Torso
	Internal
	Back
	Shoulder
	Hand (Left)
	Hand (Right)
	Foot (Left)
	Foot (Right)
	Amputation
	Asphyxia

	Contagious
	Contusion/Bruise
	Cut/Puncture
	Dermatitis
	Poisoning
	Electric Shock
	Foreign Body (Eye)
	Unconsciousness
	Scratch
	Radiation

	Hernia
	Strain
	Sprain
	Infection
	Fracture
	Hearing
	Burn

Supervisor Accident Investigation & Report of Findings

ACCIDENT DESCRIPTION

Describe fully how the accident/near miss occurred:_____

_____

_____

_____

_____

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

_____

_____

What was the cause of the accident/near miss?

_____

_____

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

Was the accident/near miss the result of unsafe act(s)? **Yes**☐ **No**☐
If yes, please explain:_____
_____

Were unsafe work conditions a factor in the cause of the accident/near miss? **Yes**☐ **No**☐
If yes, please explain:_____
_____

Were any unsafe conditions reported or observed prior to the accident? **Yes**☐ **No**☐
If yes, please explain:_____
_____

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

Entering or Leaving Work ☐ **During Meal/Break** ☐ **During Work Related Travel** ☐

During Normal Work Activity ☐ **During Overtime Shift** ☐

Supervisor Accident Investigation & Report of Findings

What is your recommended preventative action?

_____

_____

How and when do you plan to implement preventative measures?

_____

_____

Additional Comments *(Supervisors - please note whether medical care was offered and if the staff member accepted or declined)***:**

_____

_____

_____

_____

I certify that all above statements are true and accurate to the best of my knowledge:

_____ _____

Supervisor Signature **Date**

Reviewed by:_____ **Date:** _____

FORM REVISED 7.26.24

Witness Statement of Workplace Injury/Illness/Near Miss

I AM REPORTING AN: INJURY☐ ILLNESS☐ NEAR MISS☐

Witness Name:_____

Witness Contact Number:_____

Name of Employee Involved in Accident:_____

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

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☐**

Was the affected employee working at the time of the accident/near miss? **Yes☐** **No☐**

To the best of your knowledge, was the affected employee following safety procedures? **Yes☐** **No☐**

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

_____

What was the employee doing 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:_____

_____

_____

_____

I certify that all above statements are true and accurate to the best of my knowledge:

_____

WITNESS SIGNATURE

FORM REVISED 7.26.24