

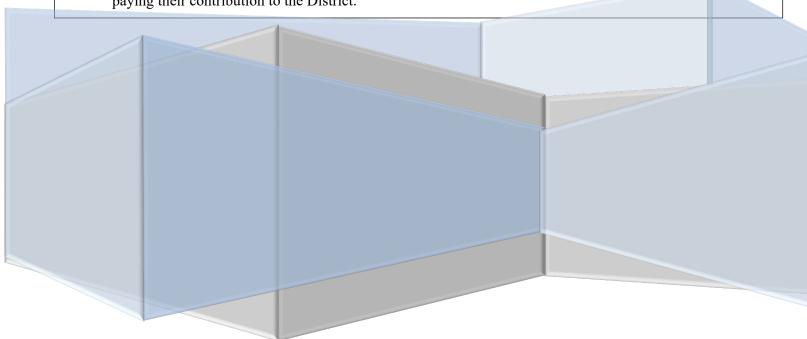
## WORK RELATED INJURY PROCEDURES AND REPORTING FORM

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Hamilton Wenham Regional School District provides a workers' compensation insurance program at no cost to its employees. This insurance program can provide wage replacement and medical benefits to employees injured during the course of employment.

- 1. All employee injuries should be reported on a First Report of Injury Report by the injured employee and/or their Supervisor and submitted to the Human Resources Department within 24 hours. Human Resources will determine the appropriate course of action, and file any relevant claims for workers' compensation. No matter how minor a work-related injury may appear, it is important that it be reported as promptly as possible. Please fill out every question and have this signed by your supervisor.
- 2. <u>Injured employees should seek necessary medical care or treatment, and should inform their medical care provider that the injury or illness is work-related</u>. If the employee is seriously injured and cannot be moved, the Supervisor or an appropriate staff member should call for an ambulance.
- 3. Employees should not perform tasks that are not detailed in their job descriptions, such as moving furniture and appliances or snow shoveling.
- 4. While out of work due to a work-related injury, voluntary benefits (such as group medical insurance) will remain in effect if the employee makes arrangements through the District Accountant to continue paying their contribution to the District.





## **EMPLOYER'S FIRST REPORT OF INJURY**



NAME:	SOCIAL SECURITY#
ADDRESS ST:	TELEPHONE: (h)
CITY, ST, ZIP:	TELEPHONE: (w)
MARITAL STATUS: Single Married	SEX: Male Female
DATE OF HIRE:	DATE OF BIRTH:
OCCUPATION:	DEPARTMENT:
AVG WEEKLY WAGE: \$	NUMBER OF DEPENDENTS:
DATE OF INJURY:	LOCATION INJ OCCURRED:
Time of Injury:	WITNESS TELEPHONE:
Time of Day they started Work:	THEIR POSITION:
WITNESS:	
TO WHOM WAS THE INJURY REPORTED	WAS TIME FROM WORK LOST? YNN NEDICAL TREATMENT SOUGHT? YNN N
DATE INJURY WAS REPORTED:	MEDICAL FACILITY:
DATE RETURNED TO WORK:	RETURNED TO WORK?
LOCATION WHERE INJURY OCCURRED:	SOURCE OF INJURY: (fall, machinery, chemicals)
BODY PART(S) INJURED:	EMPLOYEE SIGNATURE
DESCRIPTION OF INJURY:	
WHAT CAUSED THE UNSAFE CONDITION?	
WAS SAFETY GEAR BEING WORN Y N IF	NO, SHOULD IT HAVE BEEN: Y N
WAS ACTION TAKEN TO PREVENT A SIMILAR ACCIDENT I	IN THE FUTURE Y N IF YES, EXPLAIN
DATE CENTRAL OFFICE WAS NOTIFIED:	WHO WAS NOTIFIED?
EMPLOYER REMARKS:	
EMPLOYER'S REP NAME:	TITLE:
EMPLOYER'S REP SIGNATURE:	DATE PREPARED: