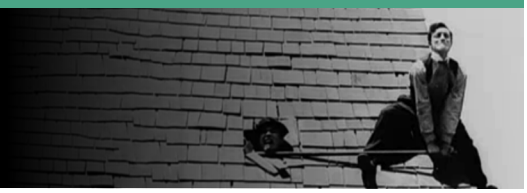
IN CASE OF WORKPLACE INJURY

ACCION a seguir en caso de un accidente en el trabajo

COMPANY NURSE™
Because Accidents Happen™



AVAILABLE 24 HOURS A DAY

1-877-223-9311

Employer Name (Nombre De Compania)	Search Code (Código Del Búqueda)
	TLMNE

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

2. **Supervisor/Injured worker immediately calls injury contact center.**
   Supervisor / Empleado lesionado llama de imediato al centro de contacto para lesiones.

3. **Company Nurse gathers information over the phone and helps injured worker access appropriate medical treatment.**
   Company Nurse obtiene información por teléfono y asiste al empleado lesionado en adquirir 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.

Tuolumne JPA
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EMPLOYEE/SUPERVISOR INCIDENT REPORT

Please report all injuries within 24 hours

Email completed report to: nwallace@tcsos.us

Tuolumne JPA – Attn: Norma Wallace

EMPLOYEE SECTION

Employee must complete and return to Supervisor within 72 hours.

Employee Last Name	Employee First Name	Employee Position Title

Home Address	City	ZIP

Work phone	Home phone	Work Site	Supervisor/Principal Name and Title

Date of Incident	Time of Incident ☐ am ☐ pm	Date Reported	Time reported ☐ am ☐ pm	Employee shift/hours worked

Where did accident/exposure occur?

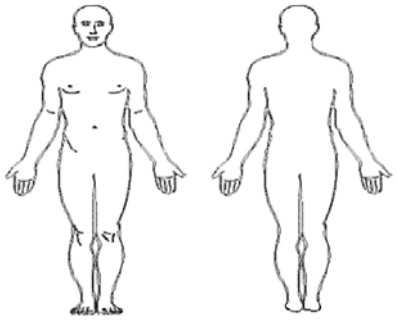
Site	Address	City	Zip

Description of Incident (What were you doing when injured?) Attach additional sheet if necessary.

Area(s) of Injury:

☐ Abdomen	☐ Wrist	☐ Chest
☐ Arm(s)	☐ Back	☐ Leg(s)
☐ Hand	☐ Knee	☐ Foot
☐ Head	☐ Neck	☐ Other

FRONT BACK



PLACE AN X OVER INJURED AREA(S)

Have you ever been treated for a similar injury/illness?

☐Yes ☐No

If yes, What was the date of injury?

Name/address of treating physician:

Witnesses to the incident	Job Title	Department	Phone Number

Please specify if any of the following personal protective equipment would have been useful in preventing your injury

☐ Eye Protection ☐ Kevlar Arm Guards ☐ Gloves ☐ Proper Footwear ☐ Face Mask ☐ Hand Truck/Cart

☐Other

IMPORTANT! **Information on Employee Workers' Compensation Rights and the Medical Provider Network is attached to this report. Please read this information and keep for your records and initial below that you received the information.**

I have received information regarding my Workers' Compensation benefits ☐ Yes ☐ No **Initial here**

I have received information regarding the Workers' Compensation Medical Provider Network (MPN)

☐ Yes ☐ No **Initial here**

I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING IS CORRECT AND TRUE.

Employee Signature **Date Report Completed**

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SUPERVISOR INVESTIGATION SECTION

Supervisor must complete the following report and submit to Human Resources & Tuolumne JPA within 72 hours.

Supervisor Last Name	Supervisor First Name	Supervisor Position Title

Name of employee involved in incident	Work Site

Date of Incident	Time of Incident ☐ am ☐ pm

Did employee miss work due to incident? ☐ Yes ☐ No	If employee is off due to incident, estimated # of days off from work:	Estimated date of return to work

Supervisor Description of Incident:

What contributed to the incident? Check all that apply.

☐ Distracting Activities	☐ Working on moving equipment	☐ Result of employee error	☐ Caught in/under/between object
☐ Failure to use personal protective equipment	☐ Altercation with student	☐ Defective tools/equipment	☐ Fall/slip or trip
☐ Operating at unsafe speed		☐ Collision with fixed object	☐ Human bite
☐ Struck by falling/flying object		☐ Hazardous arrangement	☐ Other
☐ Taking unsafe position		☐ Inadequate lighting	
☐ Unsafe clothing			
☐ Body/fluid exposure			
☐ Unsafe design or construction			
☐ Using equipment unsafely			
☐ Using unsafe equipment			

Was Weather a factor in the incident?
☐ Yes ☐ No If yes, check all that apply.

☐ Dust	☐ Wind	☐ Extreme Cold	☐ Extreme heat
☐ Indoors	☐ Rain	☐ Poor visibility	☐ Unknown
☐ Other_____			

Supervisor's knowledge of prior experiences relating to this incident:

Supervisor Plan of Action

☐ No planned action needed. Explain:

☐ Possible disciplinary action required	☐ Discussed with employee SBCSS safety practices, policies and procedures
☐ Install guard or protective device	☐ Repair, remove or replace unsafe equipment

☐ Follow up needed by:	☐ Supervisor	☐ Facilities	☐ Risk Management Services
☐ Human Resources	☐ Other:		

Supervisor's Signature	Date: