ROMOLAND SCHOOL DISTRICT

SUPERVISOR CHECKLIST

- ☐ Review and obtain initials of the injured employee on the **Instructions for Injured Workers** form with injured employee
- ☐ Complete the **Supervisor's Incident Investigation Report**
- ☐ Review and collect the **Accident Witness Statement** *(if applicable)*
- ☐ Work with HR on a **Return to Work** *(If applicable)*
- ☐ Return completed Supervisor packet to Business Office

Clear Form

INSTRUCTIONS FOR INJURED WORKERS

Business Services
(951) 926-9244 Ext. 1224
FAX: (951) 926-2170

By initialing below, I acknowledge that I understand and am in agreement with the following:

IF YOU ARE INJURED AT WORK

Initial: _____

Report it to the Secretary or Supervisor immediately and you will be given the following 5 forms to complete and return:

1. Employee Statement of Occuopational Injury or Illness
2. State of California Claim Form (DWC-1) (retain Notification of Potential Eligibility (NOPE), last 3 pages of DWC-1)
3. Complete Written Employee Notification
4. Authorization for Release of Patient Health Information/Medical Treatment Authorization for Injured Employees
5. CADENCE Rx Workers' Compensation Prescription Information

** Once copies are made, all originals will be given to you.

The Employee Statement of Occupational Injury form lets us know whether you wish to accept treatment at a clinic designated by Company Nurse, decline treatment by a physician, or go to the physician that you pre-designated at a prior date.

IF YOU NEED TO SEE A DOCTOR

Initial: _____

Check the box on the Employee Statement of Occupational Injury form that states: "*accept*"

☑ - If you have previously filed a pre-designation form with Romoland School District's HR office and wish to be treated by your own pre-designated physician, place a check mark in the last row and fill in your physician information in the space provided.

☑ - If you do not have a pre-designation on file, go to the clinic that Company Nurse has directed you to.

IF YOU DO NOT NEED TO SEE A DOCTOR

Initial: _____

Check the box on the Employee Statement of Occupational Injury form that states: "*decline*".

-If you should need medical treatment later, please notify your Supervisor or Office Manager.

-If you require medical attention over the weekend or after regular business hours, please call Company Nurse at 1-877-518-6702. They will direct you to the appropriate facility

IF MEDICATION OR DURABLE MEDICAL EQUIPMENT IS PRESCRIBED (E.G., BRACE, CRUTCHES, WALKER, ETC.):

Initial: _____

Authorization is necessary from Keenan. Please see the Pharmacy instructions for address and phone numbers (*included in this packet*).

KEEP ALL SCHEDULED APPOINTMENTS

Initial: _____

If you cannot keep an appointment, notify the clinic ASAP and Keenan at 800-654-8347 or the Business Services office at (951) 926-9244 ext. 1224. *Missed appointments may result in loss of benefits.*

NOTE: Appointments (doctor, physical therapy, x-rays, etc.) should be scheduled outside your regular work hours when possible.

Continued on next page

INSTRUCTIONS FOR INJURED WORKERS

Business Services
(951) 926-9244 Ext. 1224
FAX: (951) 926-2170

IF YOU ARE REFERRED TO A SPECIALIST OR OTHER PHYSICIAN

Initial: _____

Once you have been referred to a specialist, that physician becomes your treating physician. If you are given a referral for physical therapy or other diagnostic appointments, please provide your site office manager with an appointment card showing the name of the facility and the date of your appointment.

BEFORE YOU RETURN TO WORK

Initial: _____

Obtain a *Status Report* or *Return-To-Work* slip from the treating physician: All time away from work requires authorization by the treating physician. Please review this with the physician before you leave the office so that you are aware of what is expected of you, and when you should return to work. Status notes are also required for follow-up visits to the doctor after you return to work.

IMPORTANT: It is the employee's responsibility to provide the employer a copy of the doctors' notes (clinic will provide 2 copies) and to keep his/her supervisor and the Business Services department informed of inability to report to work. All hours coded "WC" must have a note or appointment confirmation (physical therapy, labs, x-rays) to confirm reasonable time (drive + appointment time) used to attend. If no note is provided, the time will be charged to your Sick or PN leave. You should keep in contact with your site administrator weekly by phone while you are off work.

IF PHYSICIAN PRESCRIBES MODIFIED DUTIES

Initial: _____

The doctor should specify what your limitations are, including any recommended change in your normal work schedule. Please be sure you understand these limitations fully and that it is clearly written on your status report.

Modified Duties and/or changes in your work schedule require approval before you can return to work. Please follow the directions below:

1. Your Treating Physician specifies your limitations.
2. Review them with your Site Administrator.
3. Your Site Administrator, in conjunction with Human Resources, will coordinate approval.
4. If you cannot comply with the duties as stated, you should call Human Resources to discuss your situation.

Your signature below indicates that you have read and understand your responsibilities as an injured worker.

Signature: _____ Date: _____

Print Name: _____

IF YOU HAVE ANY QUESTIONS, PLEASE CALL BUSINESS SERVICES AT

(951) 926-9244 EXT. 1224

eramos@romoland.net

Continued on next page

Romoland School District
SUPERVISOR'S INCIDENT INVESTIGATION REPORT

EMPLOYEE INFORMATION

Employee Name: _____ Job Title: _____

Regular Employee? ☐ Yes ☐ No If No, Explain: _____

Was any informal or formal personnel action considered or taken against the employee within the previous twelve months? ☐ Yes ☐ No Explain: _____

Has the employee ever reported any previous physical condition(s) associated with work or non-work activities (second job, sports, etc. that could be related to or aggravated by this injury)? ☐ Yes ☐ No

If Yes, explain: _____

INJURY/ILLNESS INFORMATION

Type of Incident: ___ Injury ___ Incident Only

Date of Injury/Incident: _____ Time: _____ Date Reported: _____

How was injury/incident reported? ___ In person ___ Phone ___ Other: _____

Was the incident reported immediately? Yes - No If no, Why: _____

Did anyone witness the injury? Yes - No If so, Who: _____

- *Please Attach Witness Statement to Investigation Report*

Was Company Nurse called: Yes - No Was treatment refused: Yes - No

Employee: ___ Stayed on Job ___ Went to Physician/Clinic

Where did injury/incident occur? (Be specific, including building & room number, if applicable)

_____

_____

Where pictures taken? Yes - No

Describe how the injury occurred: (Example: employee was walking down the stairs, tripped & fell injuring right knee on the cement; employee was lifting a box, felt sharp pain in lower back.)

_____

_____

_____

Body Part: (Check appropriate line (s) and on the line provided specify the location by indicating LE for Left, RT for Right, BO for Both, FR for Front and BA for Back.

Head/Skull ___	Arm ___	Leg ___	Heart ___	Back, Upper ___
Nose ___	Elbow ___	Hip ___	Chest ___	Back, Mid ___
Ear ___	Shoulder ___	Foot ___	Lung ___	Back, Lower ___
Tooth ___	Finger ___	Knee ___	Abdomen ___	Neck ___
Mouth ___	Wrist ___	Toe ___	Mental Trauma ___	Other _____
Eye ___	Hand ___			

Nature of Injury: (Check appropriate line)

__Irritation/inflammation __Trauma/Contusion (Bruise) __Abrasion __Puncture/Laceration	__ Strain/Sprain __ Fracture __ Repetitive Motion Bite	__Emotional Stress __Exposure (to what): _____ __Other: _____

Cause of Incident/Injury: (Check appropriate line/es.)

__Rules/procedures known, but not followed __Incorrect body position in relation to work __Incorrect tools or mechanical aids used __Equipment operated incorrectly __Protective equipment not used __Distractaction/lack of required attention to task __Horseplay/Teasing __Protective equipment used improperly __Physical or mental impairment	__Uneven or slippery surface __Lack of training or skill __Exposure (chemical, noise, etc.) __Faulty/broken equipment __Congested area/poor housekeeping __Animal or insect __Action of another person __Conflict with supervisor __Environmental factors (weather,lighting) __Other: _____

Source of Incident/Injury: (Check appropriate line.)

__Behavior __Objects	__Equipment/Tools __Environment	__Material __Person	__Other: _____

CORRECTIVE ACTION

Was this accident preventable? Yes - No

What did the injured worker do or failed to do that contributed to the accident:_____

_____

Was the injured employee properly trained for what was being done? Yes - No

Was another co-worker involved in the accident? Yes - No

If yes list the names:_____

Was another company/individual involved in the accident? Yes - No

If yes list the name and contact information:_____

What did the other person do or fail to do that contributed to the accident? _____

Preventative Action Required:

__Enforce safety procedures __Provide more complete job instruction __Provide personal protective equipment	__Update or revise procedures __Submit work order to correct unsafe condition • Date work order submitted: _____ __Other: _____

Is there any reason to believe this may NOT be a valid claim? No - Yes

Prepared by _____

(Signature) (Please Print Name)

Site_____Date_____

Forward completed form to:
Business Services

Romoland School District

ACCIDENT WITNESS STATEMENT

(To Be Completed by Witness to Accident)

WITNESS INFORMATION

Witness Name (First and Last): _____

Job Title: _____ Work Location:_____

Phone Number: __(_ _ _)_ _____ Email: _____

ACCIDENT INFORMATION

Name of Injured Employee:_____

Date of Accident: _____ Time of Accident: _____ Exact Location on Site of Accident:_____ Please describe the accident you witnessed:_____

_____

_____

_____

State what body parts were injured by the employee: (Be specific, about body part(s) i.e.: left ankle, right wrist, index finger on right hand).____

_____

In your opinion what were the contributing causes to the accident?_____

_____

_____

_____

WITNESS' SIGNATURE

_____ _____

(Signature) (Please Print Name)

Date_____