**West Windsor-Plainsboro Regional School District**
321 Village Road East
West Windsor, NJ 08550
609-716-5000 FAX 609-716-5038

# WORKERS' COMPENSATION INCIDENT REPORT

**EMPLOYEE INFORMATION** (Print) Today's Date:_____

Name _____

School Location _____

Occupation_____ Supervisor_____

Work Start Time:_____ Work End Time :_____

**ACCIDENT INFORMATION**

Identify Body Part(s) Injured:_____

Date, Time, and Location of Incident:_____

Describe in **DETAIL** how the injury occurred:_____

_____

_____

Did you, as required by our protocol, report the incident immediately to the nurse/supervisor? **YES** **NO**

Do you currently feel pain? **YES** **NO**

List any witnesses to the accident: _____

**School Nurse's Treatment** (if any):_____

_____

_____

_____

☐ Employee was given a list of district approved providers if they are seeking treatment for this incident.

☐ Employee was directed to call NJSIG at 609-543-3377 (M-F 8am – 5pm) or completing the digital First Accident Report (after hours) if seeking treatment

☐ Employee was given a NJSIG Worker's Compensation card and instructed to present it to the approved provider.

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Did employee return to work: **YES** **NO**

Did employee leave work to seek treatment from an approved provider? **YES** **NO**

Was employee transported via ambulance to the ER? **YES** **NO**

Additional Instructions/Information:_____

_____

_____

_____

Nurse Signature_____ Date _____

Supervisor Signature _____ Date _____

I certify that the above statements and descriptions made by me are true and correct.

Employee Signature _____ Date _____

*Please scan this form and send it to Kelsey Sheppard in Human Resources (kelsey.sheppard@wwprsd.org)