(to be completed by SSC Manager, Nurse, Principal or designee)

MPS Employee Incident Report

(instructions on next page)

PART A — Employee Information

1. Name: Enter EE name
2. Sex: Choose
3. Assigned to: Choose   Phone: XXX-XXX-XXXX
4. Home address: Enter EE address
   Address line 2: Enter additional address
   City: City   State: ST   Zip: Zip
5. Home phone: XXX-XXX-XXXX
6. Cell phone: XXX-XXX-XXXX
7. Birth date: MM/DD/YY
8. Marital: Choose
9. Deps: Choose
10. Supervisor: Enter name
11. Employee # XXXXX
12. Position / Title: Enter EE position
13. Position start date: MM/DD/YY
14. MPS start date: MM/DD/YY
15. Position Status: Choose
16. Work days/week: Choose
17. # hrs/day: Choose
18. Shift start: Enter time -- am/pm

PART B — Injury Information

19. Injury date/time: MM/DD/YY Enter time -- am/pm
20. Injury Location: Choose Enter room, area and/or description
21. Date reported: MM/DD/YY
22. Reported to: Enter Name
23. Last work date prior to injury: MM/DD/YY
24. Type of injury (ies): *(Click all that apply)*
    ☐ Abrasion, scrapes ☐ Amputation ☐ Broken bone ☐ Bruise ☐ Burn ☐ Concussion ☐ Crushing Injury ☐ Cut, puncture ☐ Hernia
    ☐ Foreign body ☐ Dislocation ☐ Illness ☐ Sprain ☐ Strain ☐ Irritation ☐ Infection ☐ Other: Describe other
25. Body part (s) affected: *(Click all that apply)* ☐ Left ☐ Right
    ☐ Skull / Scalp ☐ Nose ☐ Shoulder ☐ Upper arm ☐ Wrist ☐ Abdomen ☐ Hip ☐ Lower leg ☐ Toes
    ☐ Eye ☐ Neck ☐ Spine ☐ Elbow ☐ Hand ☐ Tailbone ☐ Thigh ☐ Ankle ☐ Other:
    ☐ Mouth/Jaw ☐ Back ☐ Chest ☐ Forearm ☐ Finger ☐ Pelvis ☐ Knee ☐ Foot Describe other

PART C — Initial Investigation Information

26. Employee description of what happened *(what were the activities, tasks, tools, materials, equipment, positioning, people, conditions, etc.)*:
    Enter employee's detailed description of how incident occured
27. Weather: ☐ Indoors ☐ Sunny ☐ Cloudy ☐ Rain ☐ Snow ☐ Sleet/Icing ☐ Lightning   Temp: # °   Wind Speed: # mph
28. Witnesses *(anyone with knowledge of the incident)*
    Name: Enter EE name
    Phone#: XXX-XXX-XXXX
    Name: Enter EE name
    Phone#: XXX-XXX-XXXX
29. Clarifying facts or info / witness statements *(anything that can clarify)*:
    Enter info which helps further explain or that witness provides
30. Initial treatment:
    ☐ None ☐ 1st aid ☐ School Nurse ☐ Clinic/Hospital
    ☐ E.R. ☐ Hospital overnight ☐ Hospital > 24 hrs
    Name of Hospital: Enter clinic/hospital name
    NOTE: ***Employees may not change Doctor after completing the Doctor Choice form. Please notify HR with any change request***
31. Classify report as:
    ☐ Days Lost likely
    ☐ Restricted Duty likely *(see block 32)*
    ☐ Medical Visit ONLY
    ☐ Information or Record ONLY *(no medical outside of work)*
32. Possible restrictions: ☐ None
    ☐ Walking ☐ Grasping ☐ Push/Pull
    ☐ Carrying ☐ Standing ☐ Sitting
    ☐ Bending ☐ Lifting ☐ Reaching
    ☐ Completely off work
33. Form preparer name and title
    Enter Name
    Enter Title
34. Form preparer signature
    Type name – save & e-mail after date
35. Date prepared
    MM/DD/YY

SSC Managers, Nurses, Principals, Designees PLEASE save file as: Incident Report Employee name & date of incident

Save file & E-mail it to fmla-wc@mpsomaha.org or Fax to 402-715-1097

MPS Incident Reports should be completed and sent/faxed ASAP but within 24 hours (If emergency, complete when possible)

(to be completed by

MPS Employee Incident Report

SSC Manager, Nurse, Principal or designee) *INCIDENT REPORT INSTRUCTIONS*

PART A **Employee Information - PLEASE COMPLETE ALL SECTIONS**

1. Injured employee's name -- FIRST NAME, M. INITIAL, LAST NAME --
2. Pick the appropriate sex of the employee from the drop down menu
3. Pick school or building where employee's assigned. Add phone # to the department where the employee works. For example, a custodial employee's # would be the # to the custodial area. If none, use the school/building main #
4. Address where the employee lives. Be sure to include apt # or any other significant data on additional address line
5. Employee's home phone #. Include area code. If none, put N/A
6. Employee's cell phone #. Include area code. If none, put N/A
7. Date the employee was born
8. Pick the appropriate marital status of employee from the drop down menu
9. Pick # of dependents employee claims from the drop down menu
10. Immediate supervisor's name
11. Millard Employee Number
12. Employee's current MPS job position or title
13. Date employee started in current position
14. Date employee started work in MPS
15. Pick the appropriate status of the employee from the drop down menu
16. Pick the # of days normally worked/week from the drop down menu
17. Pick the # of hours the employee works each day from the drop down menu
18. Time employee started work on injury day, pick AM or PM from the drop down menu

PART B **Accident Information - PLEASE COMPLETE ALL SECTIONS**

19. Date the injury happened and Time the injury happened, pick AM or PM from the drop down menu
20. Pick school or building where the injury happened then enter room, area or description where the injury occured
21. Date that the employee 1st notified a supervisor principal, nurse, or HR of the injury
22. Name of person employee notified
23. Date that the employee last worked prior to day of injury
24. Click box to indicate injury type. If other click and write-in. Click on all that apply
25. Click box to indicate Left/Right/Both. Click body part affected. If other click and write-in. Click on all that apply

PART C **Initial Investigation Information - PLEASE COMPLETE ALL SECTIONS**

26. Describe what happened. Use full sentences. What happened to who, where, what, when, how, etc. Be thorough
27. Check weather conditions box. Temperature should be listed regardless of location
28. Names & phone # (include area code) of anyone who witnessed or has information about the injury
29. Type any pertinent information that may have been gathered since the initial indication of what happened based on scene, history, or witness input and input of any others such as co-workers, managers, principals, etc.
30. Click box indicating the initial treatment for the injury. If a clinic or hospital is used list the name of it.
31. Click box indicating classification based on your knowledge. (i.e., employee broken knee = **days lost likely**; employee knee sprain = ***restricted duty likely***; a bruised knee = ***medical visit only*** if DR. visit likely or ***record only*** if not)
32. Click box indicating any possible restrictions expected from this injury based on your knowledge
33. Name & Title of person completing form (this should be SSC Manager, Nurse, Principal, or designee)
34. Form preparer's name for signature
    NOTE: if saving and attaching to e-mail (preferred) then type name --- if printed to scan or fax, then sign as usual)
35. Date form is completed.

SSC MANAGERS, NURSES, PRINCIPALS, DESIGNEES PLEASE SAVE FILE AS: INCIDENT REPORT EMPLOYEE NAME & DATE OF INCIDENT
SAVE FILE & E-MAIL IT TO fmla-wc@mpsomaha.org OR FAX TO 402-715-1097 MPS INCIDENT REPORTS SHOULD BE COMPLETED AND SENT/FAXED ASAP BUT WITHIN 24 HOURS (IF EMERGENCY, COMPLETE WHEN POSSIBLE)