Workers' Compensation Division

Internal School District Work-Related Incident Report

Section One: Employee and Incident Information

Employer Name: Northumberland County Career & Technology Center	Employer Address: 1700-2000 West Montgomery Street, Coal Township, PA 17866	County: Northumberland

Employee Name (last, first, initial):	Home Phone #:	Gender: M ☐ F ☐	Marital Status: M ☐ S ☐ Dep.:

Home Address (street, city, state, zip code):	County:

Social Security #:	Date of Birth:	Date of Incident:	Time of Incident:	Date Reported:	To Whom Reported:

Location of Incident (building, room, etc.):	Type of Injury (cut, sprain, etc.):

Injured Body Part:	Cause of Injury (machine, tool, equipment, liquid, etc.):

Employee's Job Title:	Hours Worked Per Week:	Name of Witness(es):

Description of Incident (please describe in detail what happened):

Employee Name:	Employee Signature:	Date:
Employee's Supervisor Name:	Employee's Supervisor's Signature:	Date:

Section Three: No Medical Treatment

☐ Returned to Work ☐ Returned to Work with Modified Duties ☐ Sent Home

Supervisor's Signature: Date:

Section Four: Medical Treatment or First Aid

Type of Injury: ________ ☐ New ☐ Other (describe): ________

Treatment/First Aid: ________

Diagnosis: ________

Disposition: ________
- ☐ Return to work without limitations
- ☐ Return to work with limitations (describe): ________
- ☐ May return to work on: ________
- ☐ Follow-up appointment with: ________ on ________

Signature of medical/first aid provider ________ **Date:** ________

Medical Facility Address: