



Los Angeles Unified School District
Food Services Division



Incident Log

Name:	Employee #:	Classification:
Date:	Probationary: When did the employee start?:	
School Name:	Cafeteria Phone #:	
Cafeteria Manager:	Area Supervisor:	

Has the employee previously received any of the following: counseling, reprimand letter, U-notice?

- ☐ Yes: Please indicate date(s): _____ and attach copies of the document(s).
☐ No
☐ Unknown

Type of Incident:

<input type="checkbox"/> Drug or Alcohol Use	<input type="checkbox"/> Theft	<input type="checkbox"/> Rude, Discourteous Behavior
<input type="checkbox"/> Insubordination	<input type="checkbox"/> Fight	<input type="checkbox"/> Dereliction of Duties
<input type="checkbox"/> Other: Health and Safety		

State what occurred using SPECIFIED DETAILS (what did the employee do or fail to do, who was involved, when did it occur).

Date/Time of Accident:	Injured Employee:
On _____ (date), _____ (employee name) was derelict in his/her duty when s/he failed to follow the employee's responsibilities as outlined under subsection IV, B Information Regarding Worker's Compensation in the FSD Employee Handbook. Specifically, the employee failed to perform the following:	
A	Did not notify me of the injury until _____ (date)
B	Bring me back a doctor's note until _____ (date)
C	Did not call me with a status on his/her condition until _____ (date)
D	Failed to give me work restrictions until _____ (date)
E	Other

On _____ (date) I received "IV Information Regarding Worker's Compensation, Subsection A Employee's Responsibilities (see attached). Employee must complete assignments as identified in sections _____ above and give me a copy by _____ (date). Any future violations will result in further disciplinary action up to and including dismissal.

Employee submitted a written statement: ☐ Yes ☐ No

Manager's Signature: _____ Date: _____

By my signature below, I certify that I have received a copy.

Employee's Signature: _____ Date: _____

If there were witnesses, list the name(s) and attach copies of their WRITTEN STATEMENTS.

1	4
2	5
3	6

*Use additional sheets if necessary.

**Obtain employee's signature when you counsel employee about the incident(s)

IV. Information Regarding Worker's Compensation

Pre-Designation of Personal Physician:

Employees wishing to designate their own personal physician to treat worker's compensation injuries must fill out a Pre-Designation form prior to any work comp. injury occurring. If designation is not on file employees will be treated by the Medical Provider Network (MPN). Pre-designation forms as well as any other forms listed below may be obtained at the LAUSD website: www.lausd.net under Offices; click on Office of Risk Management and Insurance Services; click on Worker's Compensation; then click on Publications.

A. Employee's Responsibilities

ALL injuries, regardless of the severity, will be reported to their Manager **immediately** after the accident occurs. If the Manager is unavailable, the employee should inform the Area Food Services Manager. If professional medical attention is required, the employee must:

1. Complete an employee's portion of the Worker's Compensation Claim Form (DWC 1) as to how the accident occurred if the employee is able to do so prior to seeking medical attention.
2. Obtain a Medical Authorization Form (Attachment B) from his/her Manager authorizing medical services to be rendered by an MPN. If the employee has pre-designated their own physician to treat them for industrial injuries the employee may seek medical attention with his/her own physician.
3. Go to the specified medical facility for treatment.
4. If physically capable, return to the school site and submit the Doctor's Work Status Report to the Cafeteria/Office Manager, AFSS or Personnel Unit where applicable.
5. Please note: after going to the medical facility, the employee must immediately bring the doctor's Work Status Report back to the work site. If the employee is unable to return to the site due to the seriousness of the injury, a family member or friend must bring the Work Status Report to the Cafeteria Manager by the next business day of receiving professional medical treatment.
6. Obtain a Salary Continuation Benefits Verification Form if you are required to make appointments during working hours so your time can be properly be paid under worker's comp. All appointments must be made at times that will least impact the cafeteria operations.
7. The Food Service Branch will make every effort to accommodate an employee's limitations/restrictions due to an injury. This allows the employee to continue earning at his/her regular rate of pay while also protecting his/her injury. The Personnel Unit must review all work restrictions prior to allowing an employee to return to work. Please fax restrictions immediately to Personnel (213) 241-8476 and call the appropriate Human Resources Representative.