



LOS ANGELES UNIFIED SCHOOL DISTRICT
Workers' Compensation Incident/Injury Report Worksheet
Call 1-800-LAUDWC
1-800-528-7392

Employee's Assigned Location	Location Code
Date of Incident/Injury	Time of Incident/Injury
Date Incident/Injury Reported to District	Time Incident/Injury Reported to District
Caller's Name/Title	Caller's Phone Number

Employee Information

Employee ID #	Employee Name
Work Phone	Home Address
Home Phone	
Employee Title	
Supervisor's Name/Title	Supervisor's Phone Number

Incident/Injury Information

Description of Incident/Injury	
Cause of Incident/Injury (lifting, slip and fall, etc.)	Primary Body Part Injured (lower back, left/right hand, etc.)
Nature of Incident/Injury (strain, burn, contusion, etc.)	Was Medical Treatment Received ___Y___N Did employee go to the Emergency Room ___Y___N
Medical Provider Information (If Applicable)	Name of Hospital/Clinic
Name of Doctor	Address of Hospital/Clinic
Phone Number	
Incident/Injury Location (If different from Employee's Assigned Location)	
Witness Name/Phone Number	Witness Name/Phone Number

State Information

Location where incident/injury or exposure occurred (classroom, cafeteria, etc.)	Were other employees injured/ill in this event?
Equipment, materials, and chemicals that the employee was using when the incident/injury or exposure occurred	Specific activity the employee was performing when the incident/injury or exposure occurred

OSHA Information

Was there medical treatment beyond First Aid?
Did the employee lose consciousness?
Did a health care professional diagnose a significant injury or illness?
Did the injury of illness involve a needle stick from a contaminated needle?
Was the employee hospitalized overnight as an in-patient?
What time did employee begin work?