VICTOR VALLEY UNION HIGH SCHOOL DISTRICT
16350 Mojave Drive
Victorville, CA 92395
(760) 955-3201

EMPLOYEE STATEMENT OF OCCUPATIONAL INJURY OR ILLNESS

EMPLOYEE PERSONAL INFORMATION

EMPLOYEE NAME: ____________________ EMPLOYMENT SITE: ____________________

HOME ADDRESS: ____________________ PHONE NUMBER: ____________________

____________________ DATE OF BIRTH: ____________________

____________________ SOCIAL SECURITY #: ____________________

PLEASE CHECK ALL THAT APPLY:

☐ FULL TIME ☐ CLASSIFIED ☐ CONFIDENTIAL ☐ SUBSTITUTE ☐ STUDENT
☐ PART TIME ☐ CERTIFICATED ☐ MANAGER/SUPERVISOR ☐ SHORT TERM

PLEASE ANSWER ALL THE QUESTIONS BELOW AND SUBMIT TO YOUR SUPERVISOR.

1. DATE OF INJURY/ILLNESS: ____________________
2. TIME YOU BEGAN WORK: ______ ☐ AM ☐ PM TIME OF INJURY: ______ ☐ AM ☐ PM
3. ADDRESS WHERE INJURY/ILLNESS OCCURRED: ____________________
4. DEPARTMENT/SITE WHERE EVENT OCCURRED: ____________________
5. PLEASE STATE SPECIFIC PART OF BODY AFFECTED AND TYPE OF INJURY: ____________________
6. PLEASE STATE EQUIPMENT, MATERIALS AND/OR CHEMICALS BEING USED WHEN INJURY OCCURRED
7. EXPLAIN THE CIRCUMSTANCES AND/OR ACTIVITY RELATED SPECIFICALLY TO THE INJURY/ILLNESS. DESCRIBE THE SEQUENCE OF EVENTS THAT LED TO THE INCIDENT THAT DIRECTLY AFFECTED THE INJURY/ILLNESS (USE BACK OF FORM IF NECESSARY.)
8. WAS ANYONE ELSE INJURED? ☐ NO ☐ YES: (IDENTIFY) ____________________
9. WHO DID YOU NOTIFY REGARDING THIS ACCIDENT/ILLNESS: ____________________
10. PLEASE NAME ANY WITNESSES: ____________________
11. WAS THIS ACCIDENT PREVENTABLE ____________________
12. WHAT STEPS HAVE BEEN TAKEN TO PREVENT SIMILAR ACCIDENTS: