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

# SUPERVISOR STATEMENT OF OCCUPATIONAL INJURY OR ILLNESS

***PLEASE ANSWER ALL THE QUESTIONS BELOW AND SUBMIT TO FISCAL SERVICES WITHIN 24 HOURS.***

EMPLOYEE NAME: _____ EMPLOYMENT SITE: _____

OCCUPATION: _____ DATE REPORTED: _____

DATE OF INJURY: _____ ON EMPLOYER'S PREMISES? ☐ NO ☐ YES

TIME OF INJURY: _____ ☐ AM ☐ PM TIME EMPLOYEE BEGAN WORK _____ ☐ AM ☐ PM

WAS ANYONE ELSE INJURED? ☐ NO ☐ YES SPECIFY NAME(S): _____

1. WHERE DID ACCIDENT/ILLNESS/EXPOSURE OCCUR: _____
2. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED: _____
3. EQUIPMENT, MATERIALS OR CHEMICALS EMPLOYEE WAS USING WHEN EVENT/EXPOSURE/ILLNESS OCCURRED: _____
4. SPECIFIC ACTIVITY EMPLOYEE WAS PERFORMING WHEN EVENT/EXPOSURE/ILLNESS OCCURRED: _____
5. HOW INJURY/ILLNESS OCCURRED (DESCRIBE SEQUENCE OF EVENTS, SPECIFIC OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS.) **USE SEPARATE SHEET IF NECESSARY** _____
6. WAS A DOCTOR SEEN? ☐ NO ☐ YES, PLEASE IDENTIFY BELOW:
   ☐ DESERT VALLEY MEDICAL ☐ INDUSTRIAL MEDICAL SERVICES ☐ PRE-DESIGNATED PHYSICIAN
   ☐ CLOSEST HOSPITAL: _____ HOSPITALIZED? ☐ NO ☐ YES
7. WAS FIRST AID APPLIED? ☐ NO ☐ YES, DESCRIBE: _____
8. WAS EMPLOYEE UNABLE TO WORK ON ANY DAY **AFTER** INJURY? ☐ NO ☐ YES LAST DAY WORKED _____
9. HAS EMPLOYEE RETURNED TO WORK? ☐ NO, STILL OFF WORK ☐ YES, DATE _____
10. WAS THE ACCIDENT PREVENTABLE? ☐ NO ☐ YES, EXPLAIN _____
11. WHAT STEPS HAVE BEEN TAKEN TO PREVENT SIMILAR ACCIDENTS? _____

**SUPERVISOR SIGNATURE** _____ DATE _____