OXNARD UNION
HIGH SCHOOL DISTRICT
High Expectations and Powerful Futures for *Every* Student

REPORT OF WORK RELATED INCIDENT
RISK MANAGEMENT DEPARTMENT

NOT RECORDABLE

309 SOUTH "K" STREET, OXNARD, CA 93030, (805) 385-2500, FAX (805) 483-3069

DATE OF INCIDENT_____ **NAME OF EMPLOYEE**_____

OCCUPATION_____ **SCHOOL SITE**_____

PHONE:_____

1. DESCRIBE BODY PART(S) AFFECTED BY THE INCIDENT

_____

_____

2. LOCATION DESCRIPTION OF THE INCIDENT (WHAT HAPPENED)

_____

_____

_____

3. DESCRIBE HOW THIS COULD HAVE BEEN PREVENTED

_____

_____

4. LIST OF WITNESSES

_____ _____ _____

I acknowledge that this report is for the sole purpose of documenting an incident related to work. THERE IS NO NEED FOR MEDICAL T REATMENT AT THIS TIME. I understand if medical treatment becomes necessary, that I must make a request for treatment through the principal's secretary.

_____ _____

Employee Signature **Date**

_____

Print Name