OXNARD UNION
HIGH SCHOOL DISTRICT

REPORT OF WORK RELATED INCIDENT
RISK MANAGEMENT DEPARTMENT

1800 SOLAR DRIVE, OXNARD, CA 93030, (805) 385-2500

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

_____ _____ _____

☐ **Yes - I am requesting to seek medical treatment**

☐ **No - I do not want to seek medical treatment at this time. I acknowledge that this report is for the sole purpose of documenting an incident related to work.**

_____ _____

Employee Signature **Date**

_____

Print Name