REPORT OF WORK RELATED INCIDENT
RISK MANAGEMENT DEPARTMENT

6RODGM , 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

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2. LOCATION DESCRIPTION OF THE INCIDENT (WHAT HAPPENED)

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3. DESCRIBE HOW THIS COULD HAVE BEEN PREVENTED

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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

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Revised 8.1.2022