SANTA CLARA COUNTY SCHOOLS' INSURANCE GROUP
REPORT OF EMPLOYEE INCIDENT/INJURY

DISTRICT _____ SCHOOL NAME/SITE _____

PART 1: TO BE COMPLETED BY THE EMPLOYEE

Name: _____ Emp. ID# _____

Home address: _____ Phone: _____

Sex: F / M Job Title: _____ Department: _____

To whom did you report this incident? _____ Date of injury: _____ Time of incident _____ AM / PM

Time you begin work: _____ AM / PM Were you unable to work at least one full day after the injury? Y / N

If yes, date last worked _____ Have you returned to work? Y / N If yes, date returned _____

Body part injured (Be Specific) _____ Have you gone or are you planning to go to a doctor? Y / N

If yes, state name and address of doctor: _____

Date you reported incident: _____ Location of incident: _____

How did incident occur? Be specific and detailed _____

_____

Employee's Signature: _____ Date: _____

PART II: TO BE COMPLETED BY SUPERVISOR/PRINCIPAL

TYPE OF INCIDENT: (Check one) ☐ Injury ☐ Illness ☐ Near Miss

Incident Date: _____ Where did the incident occur? _____

Did incident occur on school premises? Y / N Under school jurisdiction? Y / N Safety Rule(s) violated? Y / N

Was employee working within his/her job description? Y / N Date employee reported incident: _____

Describe the incident (How, why and what happened. Include task being performed, step by step detail of incident, and tool or object involved)

_____

_____

What caused the incident? _____

_____

Name(s) of witness(es) & phone #'s _____

_____

Describe immediate corrective action: _____

Date immediate corrective action was complete: _____ By whom: _____

Describe long term corrective action: _____

Estimated date long term corrective action will be completed: _____ By whom: _____

Additional comments: _____

Supervisor's/Principal's signature: _____ Date: _____

White Copy - District Claims Administrator Yellow Copy - Employee Pink Copy - Safety Director/Committee