TRACY UNIFIED SCHOOL DISTRICT

EMPLOYEE'S REPORT OF WORK INJURY/ILLNESS

***All* work injuries are to be reported to Supervisors immediately**

NAME: ____ DATE OF BIRTH:__________________________

ADDRESS: ____________________________________ CITY:_____________________ ZIP:___________

PHONE: __________________________ EMAIL: ______________________ EMP. ID#_______________

SITE AND LOCATION WHERE INJURY OCCURRED: ____

OCCUPATION (JOB TITLE): _______________________ DEPT. WHERE INJURY OCCURRED: _________

DATE OF INJURY/ILLNESS: _________________ TIME OF DAY: ________________am/pm

TIME YOU BEGAN WORK: ______________________________

WHAT WERE YOU DOING WHEN INJURED? HOW DID THE ACCIDENT OCCUR?

Be specific--identify equipment, tools you were using, and also what you were doing at the time of injury

____

____

____

____

DESCRIBE THE INJURY: ('cut', 'burn', 'strain', etc.)____

____

BODY PART AFFECTED: ('left wrist', 'right ankle', etc) ____

____

DATE INJURY REPORTED TO SUPERVISOR & NAME OF SUPERVISOR: ___________________________

WITNESSES TO INCIDENT: ____

____

◄DO YOU REQUIRE MEDICAL ATTENTION AT THIS TIME?

☐ Yes (Please obtain a Workers' Comp. packet from Supervisor or H.R.)

☐ No (Please sign here) ____

NOTE: If medical treatment is needed at a later date, please contact H.R. Workers' Compensation at 209-830-3260 x1306.

EMPLOYEE SIGNATURE: ___________________________________ DATE: ___________________