OCEANSIDE UNIFIED • SCHOOL • DISTRICT

WORKERS' COMPENSATION DEPARTMENT
2111 MISSION AVENUE, OCEANSIDE, CA 92058-2326
PHONE: 760-966-4035 FAX: 760-967-7178

Employee Incident Report

FOR REPORTING INJURIES & ILLNESSES DURING WORK HOURS

Instructions: Complete this form for any employee-related incident occurring or developing during employment at Oceanside Unified School District, regardless of whether it results in an injury. Please submit this form within 24 hours of the date of incident to the Workers' Compensation/ Return to Work Office by **Fax (760) 967-7178** or **Email** wctech@oside.us If an employee is unable to complete the form, the supervisor/ health clerk/ principal must complete on his/her behalf.

Note: If an accident results in hospitalization other than for observation, for 24 hours or more, or a loss of a limb (amputation) or loss of life, notify Workers' Compensation/ Return to Work Office immediately. Such accidents must be reported to Cal/OSHA within 8 hours of the event.

Notice about Workers' Compensation: Incident reporting ensures there is a record on file with the District. Completion of an incident report is not a filing of a workers' compensation claim. An employee retains his/her right to file a workers' compensation claim at a later date. Contact the Workers' Compensation/ Return to Work Office for more information.

EMPLOYEE

EMPLOYEE NAME:	EMPLOYEE ID	DATE OF BIRTH
ADDRESS (HOME):		PHONE (HOME)
JOB TITLE:	WORK HOURS (SCHEDULE):	PHONE (WORK)
DEPARTMENT:	SUPERVISOR NAME:	SUPERVISOR PHONE (WORK):
DO YOU HAVE OTHER EMPLOYMENT? ☐ YES ☐ NO	IF YES, WHERE?	

INCIDENT

DATE OF INCIDENT: _____/_____/_____ TIME INCIDENT OCCURRED: _____:_____ ☐ AM ☐ PM	TIME WORK BEGAN: _____:_____ ☐ AM ☐ PM TIME WORK STOPPED: _____:_____ ☐ AM ☐ PM
LOCATION OF INCIDENT (BUILDING NAME, ROOM NUMBER, ETC.)	
DESCRIPTION. HOW DID THE INCIDENT OCCUR? WHAT WAS THE ACTIVITY AND ANY TOOLS, EQUIPMENT, OR MATERIALS YOU WERE USING? ***(Example: I was opening a box of paper using a razor blade. The razor blade slipped on the surface of the box, and cut my right index finger)***	
LIST THE BODY PART(S) INJURED AND TYPE OF INJURY. ***(Example: Right index finger skin cut)***	
DID YOU REPORT THE INCIDENT? ☐ YES ☐ NO IF YES, TO WHOM?	DATE REPORTED:
WERE THERE WITNESSES? ☐ YES ☐ NO ☐ UNKNOWN IF YES, WITNESS NAME(S):	
IS THIS A NEW INJURY? ☐ YES ☐ NO IF NO, WHAT IS THE DATE OF ORIGINAL INJURY:	
WHAT COULD HAVE BEEN DONE TO PREVENT THIS INCIDENT?	

TREATMENT

EMERGENCY RESPONDERS/ 911 CONTACTED? ☐ YES ☐ NO	FIRST AID RECEIVED? ☐ YES ☐ NO
DESCRIBE FIRST AID RECEIVED:	
DID/ WILL YOU RECEIVE ADDITIONAL MEDICAL TREATMENT? ☐ YES ☐ NO (SKIP THIS SECTION)	
IF YES, LIST MEDICAL PROVIDER NAME AND ADDRESS	
FOR WORK-RELATED INJURIES: WAS COMPANY NURSE CONTACTED? ☐ YES ☐ NO	ARE YOU BEING REFERRED TO THE OCCUPATIONAL CLINIC? ☐ YES ☐ NO

Certification. *By signing this form, the employee certifies that the information provided is true and correct to the best of the employee's knowledge.*	EMPLOYEE SIGNATURE	DATE: