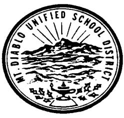

Mt. Diablo Unified School District

1936 Carlotta Drive • Concord, CA 94519

SUPERVISOR INVESTIGATION OF JOB INJURY OR ILLNESS

To be completed and submitted to Workers' Compensation Office within 24 hours of report of injury.
(Please use separate sheet of paper if additional space is needed.)

Employee Name____ Today's Date________________

Date of Hire_____________ Date of Injury/Illness______________ Employee Job Title ______________________

If not reported on day of injury, why not? ____

1. Where did injury occur? ____
2. What activity was employee engaged in when injured? ____
3. Exactly what happened to cause this injury or illness? ____
4. What part of the body was injured? (Be specific)____
5. What tool or substance was involved? ____
6. What could the employee have done to prevent this accident? _______________________________________

____

7. What could the District have done to prevent this accident? ____

____

8. Did anyone witness the accident? ☐ Yes ☐ No (If yes, collect and review statements of all witnesses)

   Name of witness(s) ____

9. Did any staff member accompany employee to treating physician? ☐ Yes ☐ No If no, why not? ____________

10. Has employee ever had a similar injury outside of MDUSD? (If yes, when and where)	☐ Yes	☐ No	☐ Not sure
11. Did employee violate any known safety rule?		☐ Yes	☐ No
12. Is there evidence that the injury did occur? (If yes, describe)		☐ Yes	☐ No
13. Has employee had any other injuries while working for MDUSD? (If yes, give date and description of injury)		☐ Yes	☐ No
14. Is employee now or recently involved in any physical, athletic, or work activities other than MDUSD? (If yes, describe)	☐ Yes	☐ No	☐ Not sure

15. Was injury caused by ☐ Unsafe act ☐ Unsafe condition ☐ Cumulative trauma ☐ Unavoidable
    If unsafe act, will employee receive ☐ Counseling ☐ Warning ☐ Suspension ☐ Termination
    If unsafe condition, was it ☐ Corrected ☐ Not corrected ☐ Not applicable
16. Date of post accident/injury investigation____

Has This Employee Been Placed on Warning for The Following

17. Attendance	☐ Yes	☐ No
18. Performance/efficiency	☐ Yes	☐ No
19. Has this employee received any written or verbal warnings in the last 12 months?	☐ Yes	☐ No
If yes, explain:		
20. Do you question the validity of this claim?	☐ Yes	☐ No
If yes, explain:		

Supervisor's Follow-Up (must be completed within 10 days of injury/illness)

Explain in detail any follow-up with employee, any action taken with employee, any other corrective action taken, results of post accident/injury review.

Any person who makes or causes to be made any fraudulent statement for the purpose of obtaining or denying workers' compensation benefits is guilty of a felony.

Supervisor's Signature____ **Phone extension**_______________

Severity: ☐ **Fatality** ☐ **Time loss** ☐ **Medical Treatment** ☐ **Other**

Rev. 10/11 Fax and send original to Workers' Compensation Office: Fax 925-680-2505 • 1 copy to be retained at site