SAN BERNARDINO CITY UNIFIED SCHOOL DISTRICT
EMPLOYEE'S REPORT OF WORK INJURY/ILLNESS

PLEASE REPORT ALL INJURIES WITHIN 24 HOURS

Complete this form and give to Supervisor
(Be sure that all areas are completely filled out)

NAME OF EMPLOYEE (First) (Middle Initial) (Last)		SOCIAL SECURITY NUMBER
HOME ADDRESS (number, street, city) Zip		PHONE (home) (work)
SEX ❑ Male ❑ Female	OCCUPATION (Regular job title, not specific activity at time of injury)	DATE OF BIRTH Month Day Year
DEPARTMENT/SITE IN WHICH REGULARLY EMPLOYED	OTHER EMPLOYMENT OR FREE LANCE WORK? ❑ Yes ❑ No	DATE OF HIRE Month Day Year
WHERE DID INCIDENT OR EXPOSURE OCCUR? (address, city, and county)		ON EMPLOYER'S PREMISES? ❑ Yes ❑ No
DATE OF INCIDENT Month Day Year	TIME OF DAY ❑ A.M. ❑ P.M.	SHIFT START TIME

WHAT WERE YOU DOING WHEN INJURED? (Please be specific, identify tools, equipment or material you were using.) (Use back if more space is needed)

NATURE OF INJURY/ILLNESS (Please be specific; identify part(s) of body, i.e., right/left, lower/upper, and type of injury i.e., sprain or laceration.)

HAVE YOU EVER BEEN TREATED FOR A SIMILAR INJURY/ILLNESS? ❑ YES ❑ NO

If yes, give date _____ and name and address of treating doctor

_____

Name of immediate supervisor: _____

Name(s) and address(es) of any witness(es) to this incident:

DO YOU REQUIRE OR DESIRE MEDICAL ATTENTION AT THIS TIME?

- ❑ Yes (If so, please obtain a Medical Service Order from your Supervisor)
- ❑ No (If not, please sign here) _____
  NOTE: If medical treatment is needed at a later date, please call 381-1166.
- ❑ I have received the "Facts for Injured Workers" brochure (please initial) _____

If you receive medical attention, please request a **Work Status Report** from the provider and provide it to your site secretary or supervisor.

***California Labor Code 5401.7 states: "Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of* obtaining or denying worker's compensation benefits or payments is guilty of felony."**

I declare under penalty of perjury the foregoing is true and correct.

Signature of Employee _____ Date report completed: _____

Original: Workers' Compensation
Photocopies: Employee
Reporting Site