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

PLEASE REPORT ALL INJURIES WITHIN 24 HOURS

To be completed by Supervisor

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		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 INCIDENT :	A.M. ❑ P.M. ❑

HOW DID INCIDENT OR EXPOSURE OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened and how it happened. Please use separate sheet if necessary.)

OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE (i.e., the machine employee struck against or which struck him, the vapor or poison inhaled or swallowed; the chemical that irritated his skin; in cases of strain, the thing he was lifting, pulling, etc.)

NATURE OF INJURY OR ILLNESS AND PART OF BODY AFFECTED (Please state right/left, lower/upper, etc.) DO NOT WAIT FOR DOCTOR'S REPORT.

IF SEEN BY A DOCTOR, NAME AND ADDRESS OF PHYSICIAN		IF HOSPITALIZED, NAME AND ADDRESS OF HOSPITAL	
HAS EMPLOYEE RETURNED TO WORK?	❑ Yes, date returned ❑ No, still off work	WAS EMPLOYEE UNABLE TO WORK ON ANY DAY AFTER INJURY?	❑ Yes, date last worked ❑ No
DID EMPLOYEE DIE?	❑ Yes, date ❑ No		

NAME AND ADDRESS OF ANY WITNESS(ES) ______________________

COMMENTS (Add anything you feel is important regarding the acceptance or denial of the claim.)

Name of Supervisor______________________ Date report completed:______________________

Signature of Supervisor ______________________

Original: Workers' Compensation

Photocopies: Reporting Site

RM-85 (Rev. 3/29/24)