Oxnard School District

EMPLOYEE STATEMENT

Name of Injured Employee:	Employee ID:	Job Title:	
Department Name:		Supervisor Name:	
Date of Injury:	Time Injury Occurred:	Time work begins: _____ ❒ AM ❒ PM	Time Work Stopped: _____ ❒ AM ❒ PM

Did you Report the Injury? If yes, to whom? Date Reported:

☐ Yes ☐ No

Is this a new Injury? ☐ Yes ☐ No If No, what is the date of original injury _____

Were there Witnesses? If Yes, Witness Name(s)

☐ Yes ☐ No ☐ Unknown

List the Body Part(s) injured and Type of Injury. (Example: Right index finger skin cut)

_____

Location of where Injury occurred (Building name, room number etc.):

_____

Specific activity you were performing when the Injury occurred:

_____

_____

Description – How did the injury occur? What was the activity and any tools, equipment, or materials you were using?

_____

_____

Emergency Responders/911 Contacted? ☐ Yes ☐ No

First Aid Received? ☐ Yes ☐ No Describe First Aid Received: _____

Was Company Nurse Contacted? ☐ Yes ☐ No Were you referred to the Occupational Clinic? ☐ Yes ☐ No

In the past, have you received any medical treatment for this same body part injured? ☐ Yes ☐ No

If Yes, list approx. date, Medical Provider Name & Address: _____

What could have been done to prevent this injury? _____

I certify that this an accurate statement in my own words, and is true and correct to the best of the my knowledge.

Signature	Date
Home Address	Cell Number

PLEASE SUBMIT FORMS TO: wcinjury@oxnardsd.org

White: Risk Management Office **Canary: Site Administrator** **Rev. July 2024**