EMPLOYEE'S REPORT OF WORK RELATED INCIDENT

RISK MANAGEMENT DEPARTMENT

1800 SOLAR DRIVE, OXNARD, CA 93030, (805) 385-2500

DATE OF INCIDENT__________________ **NAME OF EMPLOYEE**________________________________

Time:___________

OCCUPATION________________________ **SCHOOL/SITE**_______________________________________

PHONE:______________________________

1. DESCRIBE BODY PART(S) AFFECTED BY THE INCIDENT

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2. LOCATION DESCRIPTION OF THE INCIDENT (WHAT HAPPENED)

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3. DESCRIBE HOW THIS COULD HAVE BEEN PREVENTED

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4. LIST OF WITNESSES

____________________________ ____________________________ ____________________________

☐ **Yes - I am requesting to seek medical treatment**

☐ **No - I do not want to seek medical treatment at this time. I acknowledge that this report is for the sole purpose of documenting an incident related to work.**

____ ____

Employee Signature **Date**

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Print Name