

Lynwood Unified School District

Supervisor's Report of Employee Injury

EMPLOYEE INFORMATION

School: _____ Time Started Work: _____
 Name of Injured: _____
 Job Title: _____ Regular Substitute

INJURY PERSON INFORMATION

Date of Accident: _____ Time Injured: _____
 Date Reported: _____ Time Reported: _____
 Reported to Whom: _____
 Accident Location (site/room): _____
 Describe How Accident Occurred: (What was employee doing?): _____

Body part: (Check appropriate box(es) and specify on line: LE (left); RT (right) BO (both); FR (front); BA (back).)

<input type="checkbox"/> Arm _____	<input type="checkbox"/> Leg _____	<input type="checkbox"/> Back, Upper _____	<input type="checkbox"/> Head/Skull _____	<input type="checkbox"/> Heart _____
<input type="checkbox"/> Elbow _____	<input type="checkbox"/> Thigh _____	<input type="checkbox"/> Back, Lower _____	<input type="checkbox"/> Nose _____	<input type="checkbox"/> Chest _____
<input type="checkbox"/> Shoulder _____	<input type="checkbox"/> Calf _____	<input type="checkbox"/> Back, Mid _____	<input type="checkbox"/> Ear _____	<input type="checkbox"/> Lung _____
<input type="checkbox"/> Finger _____	<input type="checkbox"/> Hip _____	<input type="checkbox"/> Neck _____	<input type="checkbox"/> Tooth _____	<input type="checkbox"/> Abdomen _____
<input type="checkbox"/> Thumb _____	<input type="checkbox"/> Foot _____		<input type="checkbox"/> Mouth _____	<input type="checkbox"/> Mental (Stress)
<input type="checkbox"/> Wrist _____	<input type="checkbox"/> Toe _____		<input type="checkbox"/> Eye _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Hand _____	<input type="checkbox"/> Knee _____			

Nature of Injury: (Check appropriate box)

<input type="checkbox"/> Strain/Sprain	<input type="checkbox"/> Irritation/Inflammation	<input type="checkbox"/> Emotional Stress
<input type="checkbox"/> Contusion/Trauma/Bruise	<input type="checkbox"/> Bite	<input type="checkbox"/> Exposure (to what): _____
<input type="checkbox"/> Puncture/Laceration	<input type="checkbox"/> Repetitive Motion	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Abrasion	<input type="checkbox"/> Fracture	

Cause of Injury/Incident: (Check appropriate box(es))

<input type="checkbox"/> Rulers/procedures not followed	<input type="checkbox"/> Equipment/tools operated incorrectly
<input type="checkbox"/> Distraction/lack of required attention to back	<input type="checkbox"/> Protective equipment not used or used improperly
<input type="checkbox"/> Uneven or slippery surface	<input type="checkbox"/> Lack of training or skill
<input type="checkbox"/> Trip hazard	<input type="checkbox"/> Animal or insect bite
<input type="checkbox"/> Congested area/poor housekeeping	<input type="checkbox"/> Conflict with supervisor
<input type="checkbox"/> Action of another person	<input type="checkbox"/> Environmental factors (weather, lighting, etc.)
<input type="checkbox"/> Horseplay/Teasing	<input type="checkbox"/> Physical or mental impairment
<input type="checkbox"/> Struck by _____	<input type="checkbox"/> Inappropriate clothing/footwear
<input type="checkbox"/> Incorrect body position in relation to work	<input type="checkbox"/> Other: _____

Employee Signature: _____ (Over)

NAME OF MEDICAL FACILITY: _____

PREDESIGNATED DOCTOR: Yes Name of Doctor: _____

Pre-designated Doctor Phone Number: _____

AUTHORIZATION TO TREAT FORM GIVEN BY: _____

DID INJURED LEAVE WORK? Yes No Date: _____ Time: _____ A.M. P.M.

CORRECTED ACTION

Was this accident preventable? Yes No:

Explain: _____

Preventative action Required: _____

Enforce safety procedures

Provide more complete job instruction/training

Submit work order to have hazard corrected

Date work order submitted: _____

Provide personal proactive equipment

Updated or revise procedures

Housecleaning/cord/extension cord stored properly

Other: _____

OTHER INFORMATION

NAME OF WITNESSES: _____

_____ attach witness statements)

Is there any reason to believe this may NOT be a valid claim? No Yes

Has employee ever reported any previous physical condition(s) associated with work or non-work activities (second job, sports, etc. that I could be related to or aggravated by this injury? Yes No

If yes, Explain: _____

Prepared by: _____ Date: _____

PLEASE MAKE SURE FORM IS COMPLETE

SUPERVISOR'S SIGNATURE: _____

Forward completed form to
Risk Management