



**Mt. Diablo Unified School District**  
1936 Carlotta Drive • Concord, CA 94519

**SUPERVISOR INVESTIGATION OF JOB INJURY OR ILLNESS**

To be completed and submitted to Workers' Compensation Office within 24 hours of report of injury.  
(Please use separate sheet of paper if additional space is needed.)

Employee Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Date of Hire \_\_\_\_\_ Date of Injury/Illness \_\_\_\_\_ Employee Job Title \_\_\_\_\_

If not reported on day of injury, why not? \_\_\_\_\_

1. Where did injury occur? \_\_\_\_\_

2. What activity was employee engaged in when injured? \_\_\_\_\_

3. Exactly what happened to cause this injury or illness? \_\_\_\_\_

4. What part of the body was injured? (Be specific) \_\_\_\_\_

5. What tool or substance was involved? \_\_\_\_\_

6. What could the employee have done to prevent this accident? \_\_\_\_\_

7. What could the District have done to prevent this accident? \_\_\_\_\_

8. Did anyone witness the accident?  Yes  No (If yes, collect and review statements of all witnesses)

Name of witness(s) \_\_\_\_\_

9. Did any staff member accompany employee to treating physician?  Yes  No If no, why not? \_\_\_\_\_

10. Has employee ever had a similar injury outside of MDUSD? (If yes, when and where)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
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11. Did employee violate any known safety rule?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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12. Is there evidence that the injury did occur? (If yes, describe)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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13. Has employee had any other injuries while working for MDUSD? (If yes, give date and description of injury)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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14. Is employee now or recently involved in any physical, athletic, or work activities other than MDUSD? (If yes, describe)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
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15. Was injury caused by  Unsafe act  Unsafe condition  Cumulative trauma  Unavoidable  
 If unsafe act, will employee receive  Counseling  Warning  Suspension  Termination  
 If unsafe condition, was it  Corrected  Not corrected  Not applicable

16. Date of post accident/injury investigation \_\_\_\_\_

***Has This Employee Been Placed on Warning for The Following***

17. Attendance	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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18. Performance/efficiency	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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19. Has this employee received any written or verbal warnings in the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If yes, explain:

20. Do you question the validity of this claim?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If yes, explain:

***Supervisor's Follow-Up (must be completed within 10 days of injury/illness)***

Explain in detail any follow-up with employee, any action taken with employee, any other corrective action taken, results of post accident/injury review.

***Any person who makes or causes to be made any fraudulent statement for the purpose of obtaining or denying workers' compensation benefits is guilty of a felony.***

Supervisor's Signature \_\_\_\_\_ Phone extension \_\_\_\_\_

Severity:  Fatality  Time loss  Medical Treatment  Other