SANTA MONICA-MALIBU UNIFIED SCHOOL DISTRICT

SUPERVISOR REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Name of injured employee: _____

Department/School Site: _____

Position: _____ Employee Work Schedule, including start/stop time: _____

Date of injury or illness: _____ Time: _____ AM ☐ PM ☐

Was medical treatment offered? Yes ☐ No ☐ Was treatment refused? Yes ☐ No ☐

Was employee given a DWC-1 claim form? Yes ☐ No ☐

What type of medical treatment was given on site and by whom? _____

_____

Did the injured employee leave work due to this injury or illness? Yes ☐ No ☐ Time: _____

Has employee returned to work? Yes ☐ Date returned: _____ No, still off work ☐

Name of person to whom the injury or illness was reported: _____

If the accident was not reported immediately, at the time of injury, why not?

_____

_____

Was the injury or exposure witnessed? Yes ☐ No ☐

WITNESS INFORMATION

Name:	_____	Name:	_____
Address:	_____	Address:	_____
City/State/Zip:	_____	City/State/Zip	_____
Telephone:	_____	Telephone:	_____

Any questions or concerns, contact Robert Tisherman at (310) 450-8338, extension 70310 or rtisherman@smmusd.org

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Location where accident or exposure occurred: _____

Please go to the scene of the accident with the injured employee (if possible), have the employee explain what happened and note any facts that could have led to the injury: _____

_____

Body part injured (check all that apply and indicate left and/or right):

- ☐ Head/Skull
- ☐ Face
- ☐ Eye
- ☐ Neck
- ☐ Upper back
- ☐ Lower back
- ☐ Arm
- ☐ Wrist
- ☐ Finger (which?)
- ☐ Upper leg
- ☐ Lower leg
- ☐ Knee
- ☐ Ankle
- ☐ Foot
- ☐ Toe (which?)
- ☐ Other: _____

Nature of injury or illness:

- ☐ Scrape
- ☐ Cut
- ☐ Puncture
- ☐ Bruise
- ☐ Burn
- ☐ Sprain/strain
- ☐ Fracture
- ☐ Skin/Rash
- ☐ Repetitive Motion (over time)
- ☐ Mental Stress
- ☐ Chemical-related illness
- ☐ Foreign body (splinter/dust)
- ☐ Heat-related illness
- ☐ Loss of consciousness
- ☐ Inhalation
- ☐ Other: _____

What was employee doing at the time of injury or exposure?

_____

_____

Check any of the following unsafe actions which you feel may apply:

- ☐ Working at an unsafe speed (too fast)
- ☐ Not paying attention/carelessness
- ☐ Not following instructions
- ☐ Not trained for task causing injury
- ☐ Failure to use proper tools/equipment
- ☐ Defective tools/equipment
- ☐ Other: _____
- ☐ Not using personal protective equipment
- ☐ Unsafe lifting
- ☐ Unsafe footwear
- ☐ Running/Jumping
- ☐ Altercation, student/person
- ☐ Under influence of alcohol/drugs/medication

Is the description of injury provided by the injured employee consistent with your findings?

_____

What is the root cause of the injury to the employee:

_____

_____

If a physical hazard caused the injury, have you corrected the hazard and/or submitted a work order to correct the hazard? If not, why?

_____

If caused by an unsafe employee action or physical hazard, have you retrained your team to prevent similar accidents in the future, or when will you retrain your team?

_____

Supervisor's signature: _____ Date: _____

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