

Occupational Injury or Illness Supervisor Report

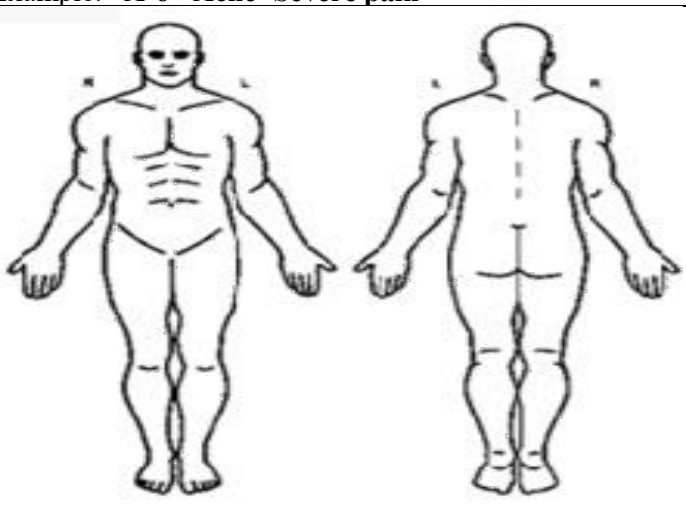
The accident should be investigated by the supervisor of the injured employee or department involved. It should be completed soon as possible to obtain the most accurate information.

Date of Injury:		Date Reported:		Employer Name:	
Name of Employee:				Occupational Title:	
Time Work Shift Began: AM/PM		Time Accident Occurred: AM/PM		Day of week Thursday	
Location:					
Injury Type					
Foreign Body in Eye	☐	Animal, Insect, Human Bite	☐	Fracture	☐
Cut/Puncture	☐	Hernia/ Rupture	☐	Amputation	☐
Abrasion/Scratches	☐	Heart Attack/Stroke	☐	Sprain/Strain	☐
Bruise/Contusion/Crushing	☐	Hearing Impairment	☐	Death	☐
Concussion/ Loss of	☐	Exposure (Chem. Temp. Elect)	☐	Other	☐
Injury Cause					
Struck by/Against Object	☐	Caught in/Under/Between	☐	Jumping or Climbing	☐
Fall-Same Level, Different Level	☐	Pushing/Pulling/Lifting/Carrying	☐	Noise	☐
Hot Object, Substance, Fire	☐	Vehicle Accident/Struck by	☐	Slipping/Tripping	☐
Was injury caused by another person, faulty/broken equipment, a vehicle? Yes ☐ No ☐					
If yes, explain:					
Body Part Injured					
Head/Neck/Face/Mouth	Wrist	L / R	n/a	Hips/ Buttocks	☐
Eye	L / R	n/a	Hand	L / R	n/a
Ear	L / R	n/a	Back(Upper,Lower)	n/a	Knee
Leg (Thigh/Calf)	Calf	Toes	L / R	n/a	Respiratory
Chest/Abdomen Including internal organs		☐			
First Aid or Medical Treatment					
Was first aid given?		Yes ☐	No ☐	If yes, by whom:	
Was medical treatment required by a physician or hospital?		Yes ☐	No ☐	Physician/ Hosp Name, Address, and telephone number:	
As a result of your investigation, what do you believe occurred and why?					
From your investigation is the validity of the accident in doubt?		Yes ☐	No ☐	If yes, explain why.	
Was a third party at fault? If yes, explain					
Were there any witnesses? If yes, please list and have witness complete attached form					
Name	Address			Phone	Date
Supervisor's Signature:				Date:	

Occupational Injury or Illness Employee Report

*If required by District.

It should be completed soon as possible to obtain the most accurate information.

Employee Name:		Employer:		
Explanation of injury (How, When, Where)				
Date you first noticed the pain?		Did this pain develop gradually?	Or suddenly?	
If the pain developed suddenly, exactly what were you doing when the pain was felt?				
If nothing unusual or unexpected happened, what do you think caused the pain?				
List body parts injured:				
Have you discussed this pain with anyone at work? If yes, with whom and when? Yes		☐	No ☐	
Have you had any recent non-work-related injuries/illnesses? If yes, please list: Yes		☐	No ☐	
If the above answer is yes, what was the problem, when did it occur, and what (if any) medical treatment did you receive?				
Show part(s) of the body injured, noting the longevity, type and degree of pain.				
On the diagram below, indicate the location, description, and level of pain you are experiencing at this time. Example: "A-6= Ache- Severe pain"				
		Note type of pain:		
		A = Ache	B = Burning	P = Pins & Needles
		N = Numbness	S = Stabbing	O = Other
		Note level of pain:		
		0	No Pain	
		1	Mild pain, you are aware of it, but it doesn't bother	
		2	Moderate pain that requires medication to tolerate the	
		3	More severe pain	
		4	Severe pain	
		5	Intensely severe pain	
6	Most severe pain, unbearable			
		Was medical treatment away from the job site offered?		
		Yes	No	
If treatment was offered, but declined, please sign:				
Have you ever received medical treatment for the injured body part(s) listed above? If so, please note the date and physician/hospital where treatment was rendered.		Yes	No	
I declare under penalty of perjury that I have examined all statements contained herein, and to the best of my knowledge and belief they are correct and complete.				
Employee Name (Print):		Date of Birth:		
Employee Signature:		Date:		