Oxnard School District

EMPLOYEE STATEMENT

Employee Name:		Employee ID:		Job Title:
Department:			Supervisor:	
Date of Injury:	Time of Injury: ❒ AM ❒ PM	Scheduled Start Time: ❒ AM ❒ PM	Scheduled End Time: ❒ AM ❒ PM	Did You Leave Work Early on Date of Injury? ❒ Yes ❒ No
Did you Report the Injury to Your Supervisor? ❒ Yes ❒ No Name: _____ Date Reported: _____ Time Reported: _____				
Is this a new Injury? ❒ Yes ❒ No If No, Please Provide Date of Original Injury _____				
Were there Witnesses? ❒ Yes ❒ No ❒ Unknown If Yes, List Witness Name(s): _____				

List the Body Part(s) Injured and describe type of Injury. (Example: Right index finger- laceration_____

Where did injury occur? (Building, parking lot, playground etc.):_____

What specific task or activity were you performing when the injury occurred?_____

Please describe how the injury occurred. Include the activity performed and identify any tools, equipment, machinery, or object involved. _____

_____

Was equipment damaged or defective? ❒ Yes ❒ No

Was PPE being used? ❒ Yes ❒ No ❒ Not Applicable If yes, list PPE being used: _____

Was photograph taken? ❒ Yes ❒ No

Were Emergency Responders (911) Contacted? ❒ Yes ❒ No

Did you receive First Aid? ❒ Yes ❒ No If yes, Describe the First Aid provided: _____

Was Company Nurse contacted before leaving work? ❒ Yes ❒ No **Were you referred to an Occupational Clinic?** ❒ Yes ❒ No

Have you previously received any medical treatment for this same body part or condition? ❒ Yes ❒ No
If Yes, provide the approx. date, Medical Provider(s) name & location: _____

In your opinion, what could have been done to prevent this injury?_____

I certify that the information provided in this statement has been completed in my own words, is true, accurate and complete to the best of my knowledge.

Employee Signature	Date
Home Address	Cell Phone Number

SUBMIT COMPLETED FORM TO: wcinjury@oxnardsd.org