Oxnard School District

EMPLOYEE INJURY INCIDENT REPORT

Instruction: This form must be completed whenever an employee reports a work-related injury or illness that does not require medical treatment or result in lost work time.

If the injury or illness requires medical treatment or results in lost work time, a Workers' Compensation Claim Form (DWC-1) must be provided to the employee within **one** (1) working day after the district receives notice or knowledge of the injury or illness.

PLEASE NOTE: All sections of this form must be completed. Incomplete forms will be returned for additional completion. Please print legibly.

Employee Name: Employee ID #		Job Title: ❒AM ❒PM
Date of Injury:	Time of Injury: ❒AM ❒PM	Date/Time reported: ❒AM ❒PM
Department/School Site:		Employee Regular Start Time:
Name of any Witness:		Supervisor Name:

Where did the injury/illness occur? _____

Provide the exact building, room or location where accident occurred

What was employee doing immediately before the injury occurred? Describe the work activity, including any equipment, tools, or material being used.

_____

Describe how the incident occurred?

_____

_____

Describe the injury or illness and identify the body parts affected.

_____

What object, equipment or substance directly caused or contributed to the injury or illness?

_____

What corrective action has been or is planned to help prevent similar incidents from reoccurring?

_____

I acknowledge that this report is completed solely to document a work-related incident. I understand that I have been offered a Workers' Compensation Claim Form (DWC-1) and medical treatment for this incident, and I voluntarily decline both at this time. I understand that if I later determine that I need medical treatment related to this incident, I must promptly notify my supervisor and/or the Risk Management Office so that appropriate workers' compensation procedures can be initiated.

I certify that the information provided on this form is true and accurate to the best of my knowledge

Signature	Date
Home Address	Cell Number

SUBMIT COMPLETED FORM TO: wcinjury@oxnardsd.org

White: Risk Management Office Canary: Site Administrator Revised July 2026