SANTA MONICA COMMUNITY COLLEGE DISTRICT
REPORT OF WORK INJURY/ILLNESS

Part I (Employee to complete)

Employee's Name_____ **Date of Birth**_____
(Last) (First)

Home Address_____**Phone Number**_____
(Street) (City) (Zip)

Date of accident_____ **Time**_____ **am/pm. Location injury occurred** _____

Sex_____ **Occupation**_____ **Dept.**_____

Certificated _____ **Classified** _____ **Full-time** _____ **Part-time** _____ **Temp** _____ **Hourly** _____

Did employee remain on the job? _____ **Was employee taken/referred to a doctor? Yes** _____ **No**_____

Name and address of Doctor/Hospital_____

_____

Describe injury, e.g. strain, cut, etc. _____ **Part of body affected, e.g. wrist, back, etc.**_____

What was employee doing when injured? (Please be specific. Identify tools, equipment or material being used.)

_____

_____

How did the accident happen? (Tell where, what and how it happened) _____

_____

Employee signature _____ **Date** _____

****

Part II (Supervisor to complete)

Comments_____

_____

What machine, tool, substance or object was most closely connected with accident?

_____

Was injury due to a contributory act of the employee? _____**/an overt act by another employee/Student?** _____

Witnesses_____

Was injury caused by unsafe conditions? _____ **If yes, has unsafe conditions been corrected?** _____

How can a recurrence be prevented? _____

Cause can be corrected by: Employee _____ **Supervision** _____ **Maintenance** _____

Signed by supervisor _____ **Date**_____

Forward original to RISK MANAGEMENT WITHIN 24 HOURS OF ACCIDENT
Supervisor to retain yellow copy

6/2016