



Injurer's Injury/Illness Incident Report

Injurer's Name: _____ Date of Injury: _____ Male Female

Campus: SKY CSM CAÑ CHANC OFFC

Category: Permanent Employee Adjunct Faculty Short-Term/Student Asst Visitor Student Volunteer

Home Address: _____ Date of Birth: _____

Home Telephone: _____ Alternative Telephone: _____ SS#: _____

Description of Incident: Time of injury/illness: _____ AM/PM Incident Location: _____

What were you doing before the incident occurred?

How did the injury occur (give all factors of contribution to accident/object/substance directly harmed you)?

What was the injury or illness (body part injured and type of injury)? _____

Witnesses Name(s): _____

Health Care:

Student Insurance Information: Advise student to report to health center if medical claim needs to be filed.

Health Center Care Treatment: College Nurse First Aid 911 Campus Security Other: _____
Care Administered by: _____

Employment/Volunteer Health Care:

Note: Must have Pre-designated Personal Physician in writing before the injury/illness occurred.
If pre-designation did not occur, must refer injurer to District Designated Medical Facility List for medical treatment.

Pre-designated Personal Physician or Facility / Physician Where Treatment Occurred Contact Information:

Name: _____ Address: _____

Were you seen in the emergency room? _____ Were you hospitalized overnight as an in-patient? _____

If no medical treatment is needed, please select the below.
 I decline medical treatment at this time. Should I decide to obtain medical treatment in the future, I will notify Human Resources and/or my supervisor. I understand that my failure to do so may cause a delay, as well as possible denial of payment for any treatment.

Employment Information:

Department: _____ Supervisor Name: _____
Job Title: _____ Date of Hire: _____ Time Work Started: _____ AM/PM

Signature of Injurer: _____ **Date:** _____



SUPERVISOR'S INJURY/ILLNESS INVESTIGATION REPORT FORM

Campus: SKY CSM CAÑ CHANC OFFC

Employee Name:			
Department:		How Long Employed:	
Job Title:		Location of Accident:	
Date Reported:		Date & Time of Accident:	
Was Employee Sent/seen by Dr?	<input type="checkbox"/> YES <input type="checkbox"/> No	If Yes, where?	
Was First Aid Given?	<input type="checkbox"/> YES <input type="checkbox"/> No	Was Time Lost?	<input type="checkbox"/> YES <input type="checkbox"/> No
First Aid Given By Whom?		How Many Days?	

IDENTIFICATION OF THE ACCIDENT FACTORS

Injury and/or Damage:																			
Brief Description of Accident (What Happened):																			
<table style="width: 100%; border: none;"> <tr> <td style="width: 15%;">Accident Type (check one)</td> <td style="width: 15%;"><input type="checkbox"/> Struck By</td> <td style="width: 15%;"><input type="checkbox"/> Fall</td> <td style="width: 15%;"><input type="checkbox"/> Inhalation</td> <td style="width: 15%;"><input type="checkbox"/> Contact With Electrical Current</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Struck Against</td> <td><input type="checkbox"/> Repetitive Motion</td> <td><input type="checkbox"/> Ingestion</td> <td><input type="checkbox"/> Exposure to Temperature Extremes</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Overextended</td> <td><input type="checkbox"/> Caught In / On / Between</td> <td><input type="checkbox"/> Absorption</td> <td><input type="checkbox"/> Rubbed or Abraded</td> </tr> </table>					Accident Type (check one)	<input type="checkbox"/> Struck By	<input type="checkbox"/> Fall	<input type="checkbox"/> Inhalation	<input type="checkbox"/> Contact With Electrical Current		<input type="checkbox"/> Struck Against	<input type="checkbox"/> Repetitive Motion	<input type="checkbox"/> Ingestion	<input type="checkbox"/> Exposure to Temperature Extremes		<input type="checkbox"/> Overextended	<input type="checkbox"/> Caught In / On / Between	<input type="checkbox"/> Absorption	<input type="checkbox"/> Rubbed or Abraded
Accident Type (check one)	<input type="checkbox"/> Struck By	<input type="checkbox"/> Fall	<input type="checkbox"/> Inhalation	<input type="checkbox"/> Contact With Electrical Current															
	<input type="checkbox"/> Struck Against	<input type="checkbox"/> Repetitive Motion	<input type="checkbox"/> Ingestion	<input type="checkbox"/> Exposure to Temperature Extremes															
	<input type="checkbox"/> Overextended	<input type="checkbox"/> Caught In / On / Between	<input type="checkbox"/> Absorption	<input type="checkbox"/> Rubbed or Abraded															

Any Witnesses? Provide Name(s):

ACCIDENT CAUSES

What Specific Act was Responsible for this Accident?
What Specific Condition was Responsible for this Accident?

REASONS - Why was the Act Committed and/or Why did the Condition Exist? (please specify on the lines below)

Lack of Knowledge/Experience Attitude Human Limitation Condition

CORRECTIVE ACTION

What Do You Suggest be Done to Prevent a Similar Accident?
<input type="checkbox"/> Instruction / Training <input type="checkbox"/> Motivation / Discipline <input type="checkbox"/> Proper Equipment Placement <input type="checkbox"/> Repair / Eliminate <input type="checkbox"/> Recommend to Manager
(Please Specify)
What Actions Have You Taken?

Supervisor Signature	Date	Administrator Signature	Date
----------------------	------	-------------------------	------

PLEASE RETURN TO HUMAN RESOURCES.