SAN DIEGO UNIFIED SCHOOL DISRICT – SUPERVISOR'S REPORT OF INJURY/ILLNESS

FOR REPORTING WORK-RELATED INJURY/ILLNESS/ACCIDENT- REFERENCE DISTRICT ADMIN. PROCEDURE 5170

ATTENTION: To be completed by the injured employee's Supervisor. All injuries must be reported. This form contains information related to employee health and must be used in a manner that protects the confidentially of employees to the extent possible while the information is being used for occupational safety and health purposes. Incomplete or illegible forms will be returned to the originating department for revision.

SUPERVISOR'S INSTRUCTIONS:

1. **REPORT THE INJURY/ILLNESS IMMEDIATELY TO RISK MANAGEMENT DEPARTMENT, PHONE (858) 627-7347.**
2. **Within 24 hours of the injury or illness:**
   a. The employee's direct supervisor must complete ALL sections of the Supervisor's Report of Injury/Illness. **(The employee never completes the form)**
   b. **Fax the Supervisor's Report of Injury/Illness and if applicable, the Declination of Medical Treatment at (858) 627-7353.**
   c. Forward the original Supervisor's Report of Injury to Risk Management once Department/Principal signs the form.
3. **In the event of a serious injury of an employee (one that might require overnight hospitalization or death), a call must be made to Cal/OSHA at (619) 767-2280 within 8 hours of the accident. Failure to do so may result in a fine up to $5,000 to the site.**

Employee Information

Employee Full Name (No abbreviations or initials)	**Position Title**	**Department Name**	**Work Phone:**
Home address **City** **Zip Code**		**SDUSD Employee ID #**	**Home Phone:**

Work Schedule Days *(check as needed)*	**Scheduled Hours on Date of Injury**		**Gender:** Male ☐ Female ☐
☐ Mon-Fri or specify days:	From : ☐ am ☐ pm	To : ☐ am ☐ pm	**Has Injured Employee Returned to Work?** ☐ Yes If Yes, Date Returned _____
☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun	# of Hours Per Week		☐ No If No, Last Date Worked _____

Injury/Illness Information

Date/Time of injury or onset of illness: _____/_____/_____ at _____:_____ ☐am ☐ pm	**Any Witness:** ☐ No ☐ Yes (If yes, please provide name)

Specific injury/illness and part(s) affected: (i.e. broken index finger on right hand, sprain in left forearm, etc.)

Describe How Injury Occurred: Provide sequence of events, specify object of exposure which directly produced the injury/illness, (i.e. Employee was walking from the classroom to the administration office when she tripped over uneven pavement and fell on both knees.) *Use separate sheet if necessary.*

Location/department where injury/illness occurred: (Must include name & address of site)

Site location: Address: City: Zip Code:

Was Employee acting within the normal course of duties: ☐ Yes ☐ No (if No, explain)

Was an outside agency/person responsible? ☐ Yes ☐ No (if Yes, specify)

Any equipment, chemical, materials, etc. used at time of injury? ☐ Yes ☐ No (If Yes, specify)

Are physical repairs necessary to site? ☐ Yes ☐ No (if Yes, describe)

Was the employee following safety procedure when injury occurred? ☐ Yes ☐ No ☐ N/A (If No, describe)

Describe corrective action that has been taken to prevent a reoccurrence:

In Your Opinion (check one):	☐ **Facts available indicated that this injury is work related and occurred during the course of employee's regular work hours and duties.**	☐ **It is unclear from the available facts known as to whether this injury is work related. Additional information may be necessary to make a determination.**	☐ **The facts available do not indicate that this injury is work related.**

Medical Treatment (EMPLOYEE RECEIVING MEDICAL TREATMENT MAY NOT RETURN TO WORK WITHOUT A MEDICAL RELEASE)

Did employee require medical treatment? ☐ **Yes** ☐ **No** ☐ **Unknown**
(When employee declines, please provide a Declination of Medical Treatment and fax to Risk Management.)

If medical evaluation/treatment required, how and where was treatment provided? (Complete appropriate box below)

☐ **Treated self** (No medical treatment sought) ☐ **Treated with school nurse** (for very minor injuries only)

☐ **Treated at Designated Medical Facilities: If so, where?** ____________________

☐ **Treated at other location:**
Medical Facility: ____________________

Address:(Street, City, Zip) ____________________ **Phone:** ____________________

Supervisor Information

Printed Name	**Title**	**Phone**

Date of supervisor's knowledge/notice of injury/illness:	**Signature**	**Date signed:**

Principal/Department Head Verification (I have reviewed Supervisor's Report of Injury/Illness.)

Printed Name	**Signature**	**Date signed:**

Original: Risk Management
Duplicate: Department/School Copy

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