Incident Only:

San Diego County Office of Education
Workers' Compensation JPA
SUPERVISOR'S REPORT OF ACCIDENT

Date of Hire _____

Type or use ball point pen and PRINT, PRESS HARD. Retain goldenrod copy for your file.

NAME OF INJURED _____ HOME ADDRESS _____

DATE OF BIRTH _____ HOME TELEPHONE NO. _____ SOCIAL SECURITY NO. _____ SEX: M ❒ F ❒

DISTRICT _____ JOB TITLE _____ FULL TIME ❒ PART TIME ❒

DATE OF INJURY OR ILLNESS _____

TIME OF DAY _____ a.m. _____ p.m.

WAS EMPLOYEE UNABLE TO WORK? ❒ Yes, date last worked _____ ❒ No

HAS EMPLOYEE RETURNED TO WORK? ❒ Yes, date returned _____ ❒ No, still off work DID EMPLOYEE DIE? ❒ Yes, date _____ ❒ No

DOES EMPLOYEE HAvE ANOTHER JOB? ❒ Yes ❒ No IF YES, WHAT IS THE NAME OF THE EMPLOYER? _____

INJURY LOCATION

❒ ATHLETIC FIELD/COURTS
❒ BATHROOM
❒ BUS STOP
❒ CLASSROOM
❒ LOCKER ROOM
❒ LUNCH AREA
❒ OTHER (SPECIFY):
❒ OFFICE
❒ PARKING LOT
❒ PLAYGROUND
❒ POOL
❒ ROADWAY
❒ SCIENCE LAB
❒ SHOP LAB
❒ SIDEWALK
❒ STAIRS

DEPARTMENT _____

PART OF BODY INJURED

❒ SIDE OF BODY: ❒ LEFT ❒ RIGHT
❒ ANKLE ❒ FINGER ❒ LEG
❒ ARM ❒ FOOT ❒ MOUTH
❒ BACK ❒ GROIN ❒ NECK
❒ CHEST ❒ HAND ❒ NOSE
❒ CHIN ❒ HEAD ❒ SHOULDER
❒ EAR ❒ HIP ❒ STOMACH
❒ EYE ❒ KNEE ❒ TOOTH
❒ FACE ❒ WRIST
❒ OTHER (SPECIFY):

NATURE OF INJURY

❒ ABRASION
❒ BITE/STING
❒ BRUISE
❒ BURN
❒ CHEMICAL EXP.
❒ CUT
❒ DISLOCATION
❒ FOREIGN BODY
❒ OTHER (SPECIFY):
❒ FRACTURE
❒ INTERNAL
❒ NO vISIBLE INJURY
❒ PAIN
❒ PUNCTURE
❒ REDNESS
❒ SPRAIN/STRAIN
❒ SWELLING

CAUSE OF INJURY

❒ ANIMAL/INSECT
❒ ANOTHER STUDENT
❒ BUILDING
❒ CHEMICALS
❒ EQUIPMENT
❒ FENCE/GATE
❒ FOOD/DRINK
❒ FURNITURE
❒ OTHER (SPECIFY):
❒ HAND TOOL
❒ POLE
❒ POWERED TOOL
❒ SELF
❒ SURFACE
❒ THROWN OBJECT
❒ vEGETATION
❒ vEHICLE

DESCRIPTION OF THE ACCIDENT

HOW DID ACCIDENT HAPPEN? WHAT SPECIFIC ACTIvITY WAS EMPLOYEE PERFORMING AT TIME OF INJURY? WHERE WAS EMPLOYEE?

SPECIFY MACHINE OR EQUIPMENT INvOLvED. _____

HOW WAS EMPLOYEE INSTRUCTED TO PREvENT ACCIDENT FROM RECURRING?

WAS THERE A vIOLATION OF APPROvED SAFETY PRACTICES/STANDARDS? ____

IF YES, WHAT? _____

WAS SAFETY DEvICE PROvIDED? _____

IF YES, WAS IT IN USE AT TIME? _____

NAMES, ADDRESSES AND TELEPHONE NUMBERS OF WITNESSES:

SUPERvISOR IN CHARGE WHEN ACCIDENT OCCURRED (ENTER NAME): _____

PRESENT AT ACCIDENT? ❒ Yes ❒ No WHEN DID SUPERvISOR FIRST KNOW OF INJURY? _____

IMMEDIATE ACTION TAKEN

Declined Treatment:

FIRST AID TREATMENT _____ BY (NAME) _____

SENT HOME _____ BY(NAME) _____

SENT TO HOSPITAL _____ BY(NAME) _____ NAME OF HOSPITAL: _____

SENT TO SCHOOL NURSE _____ BY(NAME) _____

SENT TO PHYSICIAN _____ BY(NAME) _____ PHYSICIAN'S NAME: _____

Date Employee Received *DWC Form 1 _____ *Date DWC Form 1 Returned* _____

SCHOOL _____ DEPARTMENT _____ LOCATION NO. _____

SUPERvISOR NAME _____ TITLE _____
(PLEASE PRINT)

SIGNED SUPERvISOR _____ DATE _____

**DWC Form 1 is Employee's Claim for Worker's Compensation Benefits Form*