SANTA BARBARA COMMUNITY COLLEGE DISTRICT

EMPLOYEE'S REPORT OF WORK INJURY/ILLNESS

PLEASE REPORT ALL INJURIES WITHIN 24 HOURS (NO MATTER HOW TRIVIAL)

COMPLETE THIS FORM (Be sure that all areas are completely filled out.)

Name of Employee: _____ (Last) (First) (Middle)	K Number
Home Address (Number, street and city) Zip	Home Phone: _(____)_____ Work Phone: _(____)_____
Sex Occupation (Regular job title, not specific activity at time of injury) ☐ Male ☐ Female _____	Date of Birth: _____/_____/_____ Month Day Year
Department in which regularly employed: ☐ Regular F/T-P/T ☐ Hourly ☐ Student Worker ☐ Volunteer	Date of Hire: _____/_____/_____ Month Day Year
Where did accident or exposure occur? (Room #, building, address, city and county) Time you began work: _____a.m._____p.m.	On Employer's Premises? ☐ Yes ☐ No

What were you doing when injured? (Please be specific, identify tools, equipment or material you were using.)
(Use back if more space is needed) _____

_____

_____

_____

Date of Incident _____/_____/_____ Time of Day _____a.m. _____p.m.
Month Day Year

Nature of Injury/Illness (Be specific; i.e. right/left – arm/leg – scrape/cut/burn, etc) _____

_____

_____

Have you ever been treated for a similar Injury/Illness? ☐ Yes ☐ No

If yes, give date _____/_____/_____ Name and address of treating doctor_____
Month Day Year

_____

Name of immediate supervisor _____

Name(s) and address of any witness(es) to this incident:

_____

_____

What do you recommend for preventing this type of accident? (State the specific preventive measures that can be taken by employer and workers. Do not say: "By being more careful.") _____

_____

Do you require or desire medical attention at this time?

☐ Yes (If so, please notify Risk Manager directly.)

☐ No (If not, please sign here) _____

NOTE: If medical treatment is needed at a later date, please call.

☐ I have received current information regarding my benefits (please initial here) _____

I declare under penalty of perjury that the foregoing is true and correct.

Signature of employee _____Date Report Completed: _____/_____/_____
Month Day Year

This Report must be submitted to the Risk Manager, within one working day.

A-209 Extension 2266