SANTA BARBARA COMMUNITY COLLEGE DISTRICT

SUPERVISOR'S REPORT OF EMPLOYEE INJURY OR ILLNESS

Name of Injured: _____ **Soc. Sec. No**: _____

Date of Birth: _____

Department Title: _____ **Job Title**: _____

Date of Hire: _____ **usually works** _____ hrs/day _____ days/wk _____ hrs/wk **Salary/Wage** _____

Employment status: _____ Any other employment outside SBCC? _____
Regular full-time, hourly, etc. / 12, 11, 10-month

Home address: _____ **Home Phone**: _____
Number Street City Zip

Date of injury: _____ **Day of week**: _____ **Time of day**: _____ a.m. p.m. **Time employee began work** _____

Date last worked: _____ **Date returned to work**: _____ -OR- ☐ Still off work ☐ No lost time

Date reported to supervisor: _____ Time: _____ a.m. p.m. **Claim form to employee:** Y/N _____
If yes, give date

Specific injury and body part affected or illness: _____

_____
(**Example:** Cut right hand, first degree burns on left arm, etc.)

Where did injury <u>happen</u>: _____
Building room -or- Street address, City if off campus

What equipment, tools, materials, chemicals, was employee using? _____

_____

What specific activity/task was the employee performing when injury/illness occurred? _____

_____

Write details of how the incident occurred, state facts: _____

_____

Did injured have medical aid? ☐ Yes ☐ No If yes, where? _____

☐ First Aid Only ☐ Campus Health Center Nurse

☐ Doctor (Complete name/address): _____

☐ Hospital Admission (Name/address): _____

Names of witness(es) and/or persons performing first aid / <u>addresses</u> / phone numbers: _____

_____

_____

_____ Ext: _____
Supervisor's Signature Date

ANY INJURY OR ILLNESS MUST BE REPORTED TO THE IMMEDIATE SUPERVISOR AND THE ADMINISTRATIVE SERVICES MANAGER IMMEDIATELY. THIS REPORT MUST BE SUBMITTED TO THE ADMINISTRATIVE SERVICES MANAGER WITHIN ONE WORKING DAY, ROOM A-120, EXTENSION 2266.

-See instructions on Reverse Side-

file: Supervisor's Report
revised 09/15/08