

Supervisor's Report of Work Related Injury and Illness

*This Injury and Illness Incident Report is one of the first forms you must fill out when a recordable work-related injury or illness has occurred. This form helps the school district and Cal/OSHA develop a picture of the extent and severity of work-related incidents. Within 7 calendar days after you receive information that a recordable work-related injury or illness has occurred, **you must fill out this equivalent to the Cal/OSHA Form 301.** According to CCR Title 8 Section 14300.33 Cal/OSHA's recordkeeping rule, you must keep this form on file for 5 years following the year to which it pertains.*

General Information:

Name of injured employee:		Today's date:	
Date of incident/injury:	Date reported:	Time of incident/injury:	
School Site/Department:			
Location of injury/incident:			
Time employee began work:		Case # from the Log (if applicable):	
Employee #	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of Birth:	
Home address:	Phone number where employee can be reached:		
	Job title:		
	Occupation at time of incident:		
	Months/years in occupation:		
	Date Hired:		
Pre-placement medical evaluation? Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>			
<u>Phase of employee's workday at time of injury or incident</u>			
Break <input type="checkbox"/> Entering or Leaving Facility <input type="checkbox"/> Meal <input type="checkbox"/> Performing Work <input type="checkbox"/> Other _____			
<u>Severity of injury/illness/incident</u>			
Report Only – no treatment <input type="checkbox"/> Physician Treatment <input type="checkbox"/> Light Duty-Temporary Assignment <input type="checkbox"/>			
Lost Workdays-Days Away from Work <input type="checkbox"/>		Damage to Equipment, Facility, Etc. over \$500 <input type="checkbox"/>	
Other: _____			
If the employee died, when did death occur? Date of death: _____			
<u>Other workers involved or witness to incident (attach eye-witness statements):</u>			

Information about the physician or other health care professional:

Name of physician or other health care professional: _____	
If treatment was given away from the worksite, where was it given?	
Facility: _____	
Street: _____	
City: _____	
State: _____ Zip: _____	
Was the employee treated in an emergency room?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Was employee hospitalized as an in-patient?	Yes <input type="checkbox"/> No <input type="checkbox"/>
<p><i>-If the employee required inpatient hospitalization, for other than medical observation or diagnostic testing the injury or illness must be reported to Cal-OSHA Immediately or as soon as practically possible but no longer than 8 hours after the employer knows or with diligent inquiry would have known of the injury or illness. -CCR Title 8 Section 342</i></p>	

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Injury Information (check all that applies):

Accident Type: (what caused physical harm or discomfort)	<input type="checkbox"/> Contact with <input type="radio"/> Electricity <input type="radio"/> Heat <input type="radio"/> Chemicals <input type="radio"/> Cold <input type="checkbox"/> Caught between <input type="checkbox"/> Caught in	<input type="checkbox"/> Caught on <input type="checkbox"/> Cumulative <input type="checkbox"/> Exposure <input type="checkbox"/> Fall from height <input type="checkbox"/> Slip/Trip/Fall <input type="checkbox"/> Stress <input type="checkbox"/> Struck against	<input type="checkbox"/> Struck by <input type="checkbox"/> Student caused <input type="checkbox"/> Over exertion (strain) <input type="checkbox"/> Other _____
Nature of Injury:	<input type="checkbox"/> Amputation <input type="checkbox"/> Bruise or contusion <input type="checkbox"/> Burn <input type="checkbox"/> Cut or laceration <input type="checkbox"/> Dermatitis <input type="checkbox"/> Foreign particle in eye	<input type="checkbox"/> Fracture <input type="checkbox"/> Human bite <input type="checkbox"/> Illness <input type="checkbox"/> Insect bite <input type="checkbox"/> Multiple injuries	<input type="checkbox"/> Puncture <input type="checkbox"/> Repeated trauma <input type="checkbox"/> Scratch <input type="checkbox"/> Strain or sprain <input type="checkbox"/> Other _____
Part of Body Affected:	<input type="checkbox"/> Abdomen <input type="checkbox"/> Arms: R____ L____ <input type="checkbox"/> Ankle: R____ L____ <input type="checkbox"/> Back <input type="checkbox"/> Chest <input type="checkbox"/> Elbow: R____ L____	<input type="checkbox"/> Eyes: R____ L____ <input type="checkbox"/> Face <input type="checkbox"/> Feet: R____ L____ <input type="checkbox"/> Finger: R____ L____ <input type="checkbox"/> Hand: R____ L____ <input type="checkbox"/> Head	<input type="checkbox"/> Knee: R____ L____ <input type="checkbox"/> Legs: R____ L____ <input type="checkbox"/> Shoulder: R____ L____ <input type="checkbox"/> Wrist: R____ L____ <input type="checkbox"/> Other _____

Description of how incident/injury occurred: What happened (if digital pictures are taken list picture reference numbers)?

(Attach additional pages as necessary.)

Contributing Factors

Workplace conditions that may have contributed to the accident	<input type="checkbox"/> Defective tools or equipment <input type="checkbox"/> Excessive noise <input type="checkbox"/> Failure to warn or secure <input type="checkbox"/> Inadequate guard or protection <input type="checkbox"/> Inadequate lighting	<input type="checkbox"/> Indoor air quality <input type="checkbox"/> Substandard housekeeping <input type="checkbox"/> Trip hazard <input type="checkbox"/> Vapor/Fume exposure <input type="checkbox"/> Other _____
Unsafe work practices that contributed to the accident	<input type="checkbox"/> Failure to use personal-protective equip. <input type="checkbox"/> Horseplay <input type="checkbox"/> Improper body mechanics <input type="checkbox"/> Improper lifting <input type="checkbox"/> Improper loading or placement <input type="checkbox"/> Inattention <input type="checkbox"/> Making safety devices inoperable	<input type="checkbox"/> Operating at improper speed <input type="checkbox"/> Operating equipment without authority <input type="checkbox"/> Rushing <input type="checkbox"/> Servicing equipment in motion <input type="checkbox"/> Was a code of safe practices violated? If so, which one <input type="checkbox"/> Other _____

Incidence Sequence:

List tasks being performed that led to accident. Who was involved in these tasks?	
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Findings / Root Causes (Knowledge, ability, motivation, design, maintenance, environment)

List possible causes or actions that may have contributed to the accident or incident:	
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Corrective Actions Necessary:

What corrective actions need to be taken to prevent another accident (Indicate all that apply)	<input type="checkbox"/> Disciplinary actions <input type="checkbox"/> Improve warning & posting <input type="checkbox"/> Loading or placement training <input type="checkbox"/> Lockout and tag out of energy sources <input type="checkbox"/> Operating procedures posted <input type="checkbox"/> Operator training needed <input type="checkbox"/> Provide better warning <input type="checkbox"/> Replacement or supply safety equipment	<input type="checkbox"/> Safe lifting training <input type="checkbox"/> Specific equipment or task instruction <input type="checkbox"/> Use of necessary personal protective equipment <input type="checkbox"/> Other _____ <input type="checkbox"/> Do these corrective actions need to be made at other sites also? Yes ___ No ___
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Corrective Actions Taken:

Clarify the specific corrective actions taken, who is responsible and when will they be accomplished:	
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Completed by (print name): _____

Title: _____

Phone: (____) _____

Date: _____