# Supervisor's Accident Investigation/ Injury and Illness Incident Report

**It is <u>mandatory</u> that this Injury and Illness Incident Report form be completed by a Manager/Supervisor for <u>all</u> employee work-related injuries/illnesses, regardless of whether or not medical attention is required. Please complete form thoroughly.**

Name of Injured/Ill Employee: _____

Last four Digits of Social Security Number: _____ Job Title: _____

Work Site: _____ Hours of Employment: _____ (Start Time/End Time) ☐M ☐T ☐W ☐Th ☐F ☐S ☐S (days of Week Scheduled)

Date of injury/illness: _____ Time of injury/illness: _____ ☐ AM ☐ PM

Date reported: _____ Time reported: _____ ☐ AM ☐ PM To Whom? _____

Describe injury/illness. (Provide specific part(s) of body affected and how it was affected. Examples: cut to left forearm; chemicals splashed in right eye; twisted left knee.):

Describe where injury/illness occurred. (In addition to site/location, provide detailed location information. Example: Liberal Arts building, classroom # LA-20)

Describe how injury/illness occurred. (Provide description of what the employee was doing at the time of injury, equipment being used, etc. Example: Climbing a ladder when ladder slipped on wet floor, worker fell 20 feet landing on floor; filling bottles with cleaning chemicals when chemicals splashed into eyes.):

Was this injury/illness witnessed? Provide witness information (name, address, telephone number):

Did injured/ill employee leave work? ☐ Yes ☐ No Date: _____ Time: _____ ☐ AM ☐ PM

Did injured/ill employee return to work? ☐ Yes ☐ No Date: _____ Time: _____ ☐ AM ☐ PM

Is there a safety issue or condition at the job site which needs immediate attention? ☐ Yes ☐ No

What action is needed to prevent a similar accident from occurring?

Has a work order been processed for corrective action? ☐ Yes ☐ No

If yes, work order # _____ (Copy of above cited work order attached)

What actions have been taken to ensure the safety of students and other employees?

What, if any, safety equipment had been provided to injured worker? Was equipment being used at time of injury?

Comments:

Use a separate sheet of paper if necessary.

Completed by: _____

Title: _____

Site: _____

Date: _____ Time: _____ ☐ AM ☐ PM

Upon completion of this form, immediately forward with the DWC 1 claim form to hr@cerritos.edu.