



# ORANGE COUNTY DEPARTMENT OF EDUCATION SUPERVISOR'S REPORT OF INJURY FORM

1. EMPLOYER <b>ORANGE COUNTY DEPARTMENT OF EDUCATION</b>	2. NATURE OF BUSINESS <b>EDUCATION</b>
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3. SITE NAME AND ADDRESS (e.g., Kalmus, 200 Kalmus Drive, Costa Mesa, CA 92626)

4. NAME OF INJURED EMPLOYEE	5. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	6. OCCUPATION
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7. DEPARTMENT WHERE EMPLOYEE WORKS (e.g., HR, Business Services)	8. SUPERVISOR
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9. WHERE DID ACCIDENT OR EXPOSURE OCCUR? (e.g., classroom, office, playground)	10. ON EMPLOYER PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO
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11. WHAT WAS THE EMPLOYEE DOING WHEN INJURED? (e.g., Welding seams of metal forms, loading boxes onto a truck)

12. HOW DID ACCIDENT OR EXPOSURE OCCUR? (e.g., Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld.)

13. OBJECT, EQUIPMENT, OR SUBSTANCE THAT CAUSED THE INJURY TO THE EMPLOYEE (e.g., Acetylene, welding torch, farm tractor, scaffolding)

14. WHAT IS THE INJURY OR ILLNESS, AND WHAT PART OF THE BODY IS AFFECTED? (e.g., Burned right hand)

15. DATE OF INJURY OR ILLNESS  MONTH                      DAY                      YEAR	16. TIME OF DAY  A. M.                      P. M.
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17. DATE INJURY REPORTED TO SUPERVISOR	18. NAME OF SUPERVISOR TO WHOM INJURY WAS REPORTED
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19. CLAIM FORM GIVEN TO EMPLOYEE <input type="checkbox"/> YES, DATE _____ <input type="checkbox"/> NO, EXPLAIN	20. HAS EMPLOYEE RETURNED TO WORK? <input type="checkbox"/> YES, DATE RETURNED _____ <input type="checkbox"/> NO, STILL OFF WORK
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21. WAS FIRST AID TREATMENT ADEQUATE? <input type="checkbox"/> YES <input type="checkbox"/> NO, EXPLAIN	22. DID EMPLOYEE GO TO THE DOCTOR? <input type="checkbox"/> YES <input type="checkbox"/> NO
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23. NAME OF THE DOCTOR OR CLINIC AND ADDRESS	24. DID AN UNSAFE CONDITION CONTRIBUTE TO THE ACCIDENT?  <input type="checkbox"/> YES <input type="checkbox"/> NO
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25. DESCRIBE THE UNSAFE CONDITION (IF APPLICABLE)

26. DID THE EMPLOYEE COMMIT AN UNSAFE ACT?  <input type="checkbox"/> YES <input type="checkbox"/> NO	27. DESCRIBE THE UNSAFE ACT (IF APPLICABLE)
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28. PERSONAL FACTORS THAT COULD HAVE CONTRIBUTED TO THE ACCIDENT

IMPROPER ATTITUDE                       PERSONAL FACTORS (EYESIGHT, HEARING, FATIGUE, ETC)     OTHER  
 LACK OF KNOWLEDGE OR SKILL     NO UNSAFE PERSONAL FACTOR

29. AS THE SUPERVISOR, WHAT HAVE YOU PERSONALLY DONE TO PREVENT SIMILAR ACCIDENTS?

LIST ALL WITNESSES

EMPLOYEE	DATE	SUPERVISOR	DATE
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