SUPERVISOR'S CLAIM & SAFETY REPORT OF ACCIDENT

Save typing. If you prefer, use ball point pen and PRINT.

1. NAME OF INJURED _____ HOME ADDRESS _____

HOME TELEPHONE NO. _____ SOCIAL SECURITY NO. _____ AGE _____ SEX ☐ Male ☐ Female

DATE OF BIRTH _____

2. DATE OF INJURY OR ILLNESS _____ TIME OF DAY _____ a.m. _____ p.m. ON EMPLOYER'S PREMISES? WAS EMPLOYEE UNABLE TO WORK ON ANY DAY AFTER INJURY? ☐ Yes, date _____ ☐ No

3. HAS EMPLOYEE RETURNED TO WORK? ☐ Yes, date returned _____ ☐ No, still off work DID EMPLOYEE DIE? ☐ Yes, date _____

WAGES $_____ per week FULL TIME? ☐ Yes ☐ No OCCUPATION: M/STATUS: S M D W NO. DEPENDENTS:

4. ACCIDENT CAUSE

CHECK APPROPRIATE BOXES:

STRUCK AGAINST	☐
STRUCK BY	☐
FALL ON SAME LEVEL	☐
FALL ON DIFFERENT LEVEL	☐
CAUGHT IN, OR, OR BETWEEN	☐
OVEREXERTION	☐
CONTACT WITH TEMPERATURE EXTREMES	☐
LIFTING	☐
OTHER (SPECIFY)	☐

5. DESCRIPTION OF INJURY

CHECK APPROPRIATE BOXES:

SIDE OF BODY: RIGHT ☐ LEFT ☐

ABRASION	☐	PUNCTURE	☐
SWELLING	☐	SPRAIN	☐
BRUISE	☐	ILLNESS	☐
CUT	☐		
DISLOCATION	☐		
FRACTURE	☐		
INTERNAL	☐		
OTHER (SPECIFY)	☐		

6. PART OF BODY INJURED

CHECK APPROPRIATE BOXES:

ANKLE	☐	HIP	☐
ARM	☐	KNEE	☐
BACK	☐	LEG	☐
CHEST	☐	LIP	☐
CHIN	☐	MOUTH	☐
EAR	☐	NECK	☐
EYE	☐	NOSE	☐
FINGER	☐	SHOULDER	☐
FOOT	☐	TOOTH	☐
HAND	☐	WRIST	☐
HEAD	☐		
OTHER (SPECIFY)	☐		

NAME AND ADDRESS OF PHYSICIAN/HOSPITAL

7. WHAT HAPPENED? — Describe what took place or what caused you to make this investigation

WHY DID IT HAPPEN? — Get all the facts by studying the job and situation involved. Question by use of WHY — WHAT — WHERE — WHEN — WHO — HOW

WHAT SHOULD BE DONE? — Determine which of the 12 items under EMP require additional attention.

Equipment	Material	People
Select	Select	Select
Arrange	Place	Place
Use	Handle	Train
Maintain	Process	Lead

WHAT HAVE YOU DONE THUS FAR? — Take or recommend action, depending upon your authority. Follow up – was action effective?

HOW WILL THIS IMPROVE OPERATIONS? — OBJECTIVE: Eliminate job hindrances

EMPLOYER

1. FIRM NAME: FOOTHILL-DE ANZA COMMUNITY COLLEGE DISTRICT

1A. LOCATION CODE:

2. MAILING ADDRESS (Please include city, Zip): 12345 EL MONTE RD,LOS ALTOS HILLS, CA 94022

2A. PHONE NUMBER: 650/949-6225

3. LOCATION, IF DIFFERENT FROM MAIL ADDRESS:

4. NATURE OF BUSINESS (e.g., shoe manufacturer, cabinet works): EDUCATION

5. DATE OF HIRE: ___/___/___ (Month / Day / Year)

WITNESSES

REMARKS _____

EQUIPMENT FAILURE/MALFUNCTION (DESCRIBE) _____

NON-EMPLOYEE INVOLVED (NAME/ADDRESS/PHONE) _____

AUTOMOBILE ACCIDENT (DRIVER/LICENSE PLATE) _____

UNUSUAL CIRCUMSTANCES _____

Completed by (type or print) _____ Date reported by employee _____

Signed Supervisor _____ Date _____

WHITE - INSURANCE CARRIER PINK - EMPLOYER