SUPERVISOR'S CLAIM & SAFETY REPORT OF ACCIDENT

1 Name of Injured | Social Security Number | CWID

Date of Birth _____ | Sex ☐ Female ☐ Man | Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Legal Separation | Number of Dependents _____

Home Phone Number | Alternate Phone Number | Email Address

Home Address

2 Date of Injury or Illness (mm/dd/yyyy) _____ | Time of Day _____ a.m _____ p.m | On Employer's Premises? ☐ Yes ☐ No | Was Employee Unable to Work on Any Day After Injury? ☐ Yes, Date (mm/dd/yyyy) _____ ☐ 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 _____

4 Accident Cause
Check Appropriate Boxes

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

5 Description of Injury
Check Appropriate Boxes

SIDE OF BODY ☐ RIGHT ☐ LEFT

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

6 Part of Body Injured
Check Appropriate Boxes

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

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 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

Check Appropriate Boxes

☐ 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

8 Name and Address of Physician/Hospital _____

9	Employer Name:	FOOTHILL- DE ANZA COMMUNITY COLLEGE DISTRICT	9A Location Code	Witnesses	
10	Mailing Address:	12345 EL MONTE RD, LOS ALTOS HILLS, CA 94022	10A Phone Number		
11	Nature of Business:	EDUCATION	12 Date of Hire (mm/dd/yyyy)		

Remarks _____

Equipment Failure/Malfunction (Descibe) _____

Non-Employee Involved (Name/Address/Phone) _____

Automobile Accident (Driver/License Plate) _____

Unusual Circumstances _____

Completed by (Type or Print) _____ Date Reported by Employee (mm/dd/yyyy) _____

Signed Supervisor _____ Date (mm/dd/yyyy) _____