VENTURA COUNTY COMMUNITY COLLEGE DISTRICT
HUMAN RESOURCES DEPARTMENT

SUPERVISOR'S REPORT OF EMPLOYEE INCIDENT OR INJURY

(Any employee receiving benefits as a result of this section shall, during periods of injury or illness, remain within the State of California unless the governing board authorizes travel outside the state. *Education Code §87787 & 88192)*

Please NOTE: Failure to complete form in its entirety may result in a DELAY OF BENEFITS!

TO BE COMPLETED BY EMPLOYEE or MANAGER:

❑ **INCIDENT** (no medical attention required)
❑ **FIRST AID** (per OSHA guidelines)
❑ **INJURY** (reportable to Keenan & Associates)

LOCATION:
❑ District Office ❑ Moorpark College
❑ Oxnard College ❑ Ventura College

PERSONAL INFORMATION *(Please type or print clearly)*

Employee Name: _____ SS#: _____
Home Address: _____ DOB: _____
_____ Age: _____
Home Phone: _____ Sex: ❑ Male ❑ Female
Email Address: _____

EMPLOYMENT / OCCUPATIONAL STUDENT INFORMATION *(Please type or print clearly)*

Job Title: _____ Department: _____ Ext.: _____
Work Hours: _____ Hours per Day: _____ 10 mo. Employee ❑
Work Days: _____ Days per Week: _____ 12 mo. Employee ❑
Date of Hire: _____ Wages: $_____ per _____ Time employee started work on day of injury: _____ ❑ AM ❑ PM
❑ Student Worker ❑Medical Service Provider-Professional Training
Does employee have additional employment outside the VCCCD? ❑ Yes ❑ No
If yes, please list the name of the other employer: _____

THIS SECTION AND PAGE 2 - TO BE COMPLETED BY MANAGER:

INCIDENT/INJURY INFORMATION *(Please type or print clearly)*

Accident Date: _____ Injury Reported to: _____
Accident Location: _____ Date Reported: _____
_____ Time Reported: _____
Describe the specific activity employee was performing and how the incident/injury occurred: _____
_____
_____
Describe the injury (nature of injury and specific body part(s) affected): _____
_____
_____
Name(s) of Witness(es): _____ Phone: _____
_____ Phone: _____
Was there another individual ❑ involved in or ❑ responsible for the incident/injury? ❑ Yes ❑ No
If yes, enter name here: _____ Home phone: _____
Did injured employee leave work to seek medical treatment? ❑ Yes ❑ No Date: _____ Time: _____

MEDICAL INFORMATION (*Please type or print clearly)*

Medical Facility Visited: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Doctor's Name: _____

Did doctor release injured worker to return to work? ❑ Yes ❑ No Date: _____ Time: _____

If no, estimated return to work date: _____ Was employee hospitalized? ❑ Yes ❑ No

Is modified or alternative work available in employee's department? ❑ Yes ❑ No

Accident investigation is critical for identifying the accident causes so they may be corrected. Please answer the following as completely as possible.

ACCIDENT INVESTIGATION INFORMATION *(Please type or print clearly)*

Did the accident/injury occur during the employee's regular work assignment? ❑ Yes ❑ No

If no, please explain: _____

Why did this incident happen (what was the cause)? _____

_____

Was an employee's unsafe act or disregard for safety rules or improper equipment involved? ❑ Yes ❑ No

Is additional employee training required? ❑ Yes ❑ No Must work practices be reviewed? ❑ Yes ❑ No

Has the employee suffered any other injuries, or symptoms of injury, physical and/or mental, reported or unreported, associated with this incident/injury report? ❑ Yes ❑ No

If yes, explain: _____

_____

_____

_____

(Use additional pages for above explanations as necessary)

NOTE: The State of California's "WORKERS' COMPENSATION CLAIM FORM (DWC 1)" <u>MUST</u> be provided to the employee within 24 hours of knowledge of the incident. If the employee completes this form, the supervisor should submit it to the Workers' Compensation Office immediately. If an injured employee needs treatment by a doctor or a medical facility, a "Treatment Referral Form" authorizing such treatment must also be completed for the employee.

Date State WC Claim Form was provided to employee: _____ Time: _____ Location: _____

Supervisor's Name (print): _____ Ext. _____ Campus: _____

Supervisor's Signature: _____ Date: _____

The information provided on this form is an accurate description of the accident/injury circumstances.

Injured Employee's Signature: _____ Date: _____

<u>STEPS TO FOLLOW:</u>

1. Supervisor should start the accident/injury investigation immediately.
2. Call Workers' Compensation, ext. 5533, to report any serious injury. Manager should also preserve the scene of the accident and take photos, if possible.
3. Complete and sign this form as soon as possible after the accident and fax **immediately**, along with the completed Employee's Claim for Workers' Compensation Benefits Form (DWC-1) to the Workers' Compensation Office at **(805) 652-7705**, and then place the originals in the interoffice mail. Thank you.