Ventura County Community College District
Human Resources Department

RETURN COMPLETED FORM TO:
Katy Lyon, Benefits Analyst
Human Resources Department
761 E. Daily Drive, Suite 200, Camarillo, CA 93010
Phone (805) 652-5535, Fax (805) 652-7711

SUPERVISOR'S REPORT OF EMPLOYEE INCIDENT OR INJURY

SUPPLEMENTAL QUESTIONNAIRE

(please type or print clearly)

NAME OF INJURED WORKER: _____

ADDITIONAL EMPLOYMENT INFORMATION

1. Is Injured Worker a 10 or 12 Month Employee? ❑ 10 Mo. ❑ 12 Mo.
2. Regular Work Days: _____
3. Regular Work Hours: _____
4. Total Weekly Hours: _____
5. What Is Employee's Salary? _____
6. Is Employee's Salary Being Continued? ❑ Yes ❑ No
7. Job Title: _____
8. Last Date Worked: _____
9. Was The Employee Paid a Full Day's Wages on the Date Of Injury? ❑ Yes ❑ No
10. Was the Claim Form Provided? ❑ Yes ❑ No
    On What Date? _____
    By Whom? _____
11. To Whom Was the Injury Reported? _____
12. Were There Any Safety Hazards Involved? ❑ Yes ❑ No If Yes, Explain: _____
    If Yes, Have They Been Corrected? ❑ Yes ❑ No
13. Is There An Opportunity For Subrogation Or Third Party Recovery? ❑ Yes ❑ No
14. Does The Employer Find This To Be A Questionable Claim? ❑ Yes ❑ No
    If So, Why? _____
    Is Employee Still Off Work? ❑ Yes ❑ No
16. Is the Employer Able to Accommodate Modified Duty? ❑ Yes ❑ No
17. What Date Did Employee Return To Work? _____
18. Did the Employee Return to Full or Modified Duty? ❑ Full ❑ Modified