

San Diego County Office of Education
Workers' Compensation JPA
SUPERVISOR'S REPORT OF ACCIDENT

Date of Hire _____

Type or use ball point pen and PRINT, PRESS HARD.

Retain goldenrod copy for your file.

NAME OF INJURED _____ HOME ADDRESS _____	
DATE OF BIRTH _____ HOME TELEPHONE NO. _____	SOCIAL SECURITY NO. _____ SEX: M <input type="checkbox"/> F <input type="checkbox"/>
DISTRICT _____	JOB TITLE _____ FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/>
DATE OF INJURY OR ILLNESS _____	TIME OF DAY _____ a.m. _____ p.m.
WAS EMPLOYEE UNABLE TO WORK? <input type="checkbox"/> Yes, date last worked _____ <input type="checkbox"/> No	
HAS EMPLOYEE RETURNED TO WORK? <input type="checkbox"/> Yes, date returned _____ <input type="checkbox"/> No, still off work	
DID EMPLOYEE DIE? <input type="checkbox"/> Yes, date _____ <input type="checkbox"/> No	
DOES EMPLOYEE HAVE ANOTHER JOB? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, WHAT IS THE NAME OF THE EMPLOYER? _____	

<p align="center">INJURY LOCATION</p> <input type="checkbox"/> ATHLETIC FIELD/ COURTS <input type="checkbox"/> BATHROOM <input type="checkbox"/> BUS STOP <input type="checkbox"/> CLASSROOM <input type="checkbox"/> LOCKER ROOM <input type="checkbox"/> LUNCH AREA <input type="checkbox"/> OTHER (SPECIFY): _____ DEPARTMENT _____	<p align="center">PART OF BODY INJURED</p> <input type="checkbox"/> SIDE OF BODY: <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT <input type="checkbox"/> ANKLE <input type="checkbox"/> FINGER <input type="checkbox"/> LEG <input type="checkbox"/> ARM <input type="checkbox"/> FOOT <input type="checkbox"/> MOUTH <input type="checkbox"/> BACK <input type="checkbox"/> GROIN <input type="checkbox"/> NECK <input type="checkbox"/> CHEST <input type="checkbox"/> HAND <input type="checkbox"/> NOSE <input type="checkbox"/> CHIN <input type="checkbox"/> HEAD <input type="checkbox"/> SHOULDER <input type="checkbox"/> EAR <input type="checkbox"/> HIP <input type="checkbox"/> STOMACH <input type="checkbox"/> EYE <input type="checkbox"/> KNEE <input type="checkbox"/> TOOTH <input type="checkbox"/> FACE <input type="checkbox"/> WRIST <input type="checkbox"/> OTHER (SPECIFY): _____	<p align="center">NATURE OF INJURY</p> <input type="checkbox"/> ABRASION <input type="checkbox"/> FRACTURE <input type="checkbox"/> BITE/STING <input type="checkbox"/> INTERNAL <input type="checkbox"/> BRUISE <input type="checkbox"/> NO VISIBLE INJURY <input type="checkbox"/> BURN <input type="checkbox"/> PAIN <input type="checkbox"/> CHEMICAL EXP. <input type="checkbox"/> PUNCTURE <input type="checkbox"/> CUT <input type="checkbox"/> REDNESS <input type="checkbox"/> DISLOCATION <input type="checkbox"/> SPRAIN/STRAIN <input type="checkbox"/> FOREIGN BODY <input type="checkbox"/> SWELLING <input type="checkbox"/> OTHER (SPECIFY): _____	<p align="center">CAUSE OF INJURY</p> <input type="checkbox"/> ANIMAL/INSECT <input type="checkbox"/> HAND TOOL <input type="checkbox"/> ANOTHER STUDENT <input type="checkbox"/> POLE <input type="checkbox"/> BUILDING <input type="checkbox"/> POWERED TOOL <input type="checkbox"/> CHEMICALS <input type="checkbox"/> SELF <input type="checkbox"/> EQUIPMENT <input type="checkbox"/> SURFACE <input type="checkbox"/> FENCE/GATE <input type="checkbox"/> THROWN OBJECT <input type="checkbox"/> FOOD/DRINK <input type="checkbox"/> VEGETATION <input type="checkbox"/> FURNITURE <input type="checkbox"/> VEHICLE <input type="checkbox"/> OTHER (SPECIFY): _____
--	--	---	---

DESCRIPTION OF THE ACCIDENT

HOW DID ACCIDENT HAPPEN? WHAT SPECIFIC ACTIVITY WAS EMPLOYEE PERFORMING AT TIME OF INJURY? WHERE WAS EMPLOYEE?
SPECIFY MACHINE OR EQUIPMENT INVOLVED. _____

<p>HOW WAS EMPLOYEE INSTRUCTED TO PREVENT ACCIDENT FROM RECURRING? _____ _____ _____</p>	<p>WAS SAFETY DEVICE PROVIDED? _____ IF YES, WAS IT IN USE AT TIME? _____ NAMES, ADDRESSES AND TELEPHONE NUMBERS OF WITNESSES: _____ _____ _____</p>
<p>WAS THERE A VIOLATION OF APPROVED SAFETY PRACTICES/STANDARDS? _____ IF YES, WHAT? _____ _____</p>	

SUPERVISOR IN CHARGE WHEN ACCIDENT OCCURRED (ENTER NAME): _____
PRESENT AT ACCIDENT? Yes No WHEN DID SUPERVISOR FIRST KNOW OF INJURY? _____

IMMEDIATE ACTION TAKEN

FIRST AID TREATMENT _____ BY (NAME) _____
SENT HOME _____ BY (NAME) _____
SENT TO HOSPITAL _____ BY (NAME) _____ NAME OF HOSPITAL: _____
SENT TO SCHOOL NURSE _____ BY (NAME) _____
SENT TO PHYSICIAN _____ BY (NAME) _____ PHYSICIAN'S NAME: _____

Date Employee Received *DWC Form 1 _____ Date DWC Form 1 Returned _____

SCHOOL _____ DEPARTMENT _____ LOCATION NO. _____

SUPERVISOR NAME _____ TITLE _____
(PLEASE PRINT)

SIGNED SUPERVISOR _____ DATE _____

*DWC Form 1 is Employee's Claim for Worker's Compensation Benefits Form