



SUPERVISOR'S REPORT OF EMPLOYEE INJURY

Print Name of Injured _____				
Home Address of Employee (Street Address, City, State, Zip) _____			Telephone # Home _____ Work _____ Cell _____	
Job Title _____		Employed At: <input type="checkbox"/> BCC <input type="checkbox"/> COA <input type="checkbox"/> Laney <input type="checkbox"/> Merritt <input type="checkbox"/> District Office		
Date of Injury/Accident _____		Date Employee Notified Supervisor _____	Location of Injury/Accident _____	
Describe How the Injury Occurred (Attach additional sheets as needed)				
Department in Which Employee is Regularly Employed: _____				
Hours Worked Per Day: <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Sun Total Hrs. Normally Worked Per Week _____ (This information is very important for all hourly employees)				
Did the Employee Receive Medical Treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No			If Yes, Where? (Please include address of medical facility)	
(Please attach a copy of any medical documentation).				
Did Employee Miss Any Full Days From Work? <input type="checkbox"/> Yes <input type="checkbox"/> No			Date Employee Returned to Work? _____ <input type="checkbox"/> Still off Work	
<i>PART OF THE BODY INJURED (Check all that apply)</i>				
<input type="checkbox"/> Head <input type="checkbox"/> Ear(s) <input type="checkbox"/> Eye(s) <input type="checkbox"/> Mouth/Teeth <input type="checkbox"/> Neck	<input type="checkbox"/> Back <input type="checkbox"/> Shoulder(s) <input type="checkbox"/> Arm(s) <input type="checkbox"/> Wrist(s) <input type="checkbox"/> Hand(s)	<input type="checkbox"/> Finger(s) <input type="checkbox"/> Thumb(s) <input type="checkbox"/> Leg(s) <input type="checkbox"/> Knee(s) <input type="checkbox"/> Ankle(s)	<input type="checkbox"/> Toe(s) <input type="checkbox"/> Foot/Feet <input type="checkbox"/> Emotional Distress <input type="checkbox"/> Whole Body <input type="checkbox"/> Other _____	<input type="checkbox"/> Part of Body, Not Specified <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both
<i>TYPE OF INJURY</i>				
<input type="checkbox"/> Fall from heights <input type="checkbox"/> Fall, same level <input type="checkbox"/> Struck by _____ <input type="checkbox"/> Exposure to Hazardous Substances		<input type="checkbox"/> Exposure to Infectious Substances <input type="checkbox"/> Struck-against _____ <input type="checkbox"/> Caught in or between objects <input type="checkbox"/> Overexertion	<input type="checkbox"/> Repetitive Motion <input type="checkbox"/> Heat/Cold Exposure <input type="checkbox"/> Needle Stick <input type="checkbox"/> Exposure/Contact (Electrical) <input type="checkbox"/> Insufficient Data	
<i>UNSAFE CONDITION (Check all that apply)</i>				
<input type="checkbox"/> Defective equipment - tools <input type="checkbox"/> Equipment not properly guarded <input type="checkbox"/> Poor working conditions (light, ventilation) <input type="checkbox"/> Other (Specify) _____		<input type="checkbox"/> Slippery or uneven walking surface <input type="checkbox"/> Faulty layout of facilities <input type="checkbox"/> Poor housekeeping		
What have you done to eliminate this condition? (Attach additional sheets as needed)				
<i>UNSAFE ACT (Check all that apply)</i>				
<input type="checkbox"/> Lack of training <input type="checkbox"/> Not following rules <input type="checkbox"/> Haste <input type="checkbox"/> Other (Specify) _____		<input type="checkbox"/> Not using personal safety device <input type="checkbox"/> Physical or mental handicap <input type="checkbox"/> Inattention	<input type="checkbox"/> Horseplay <input type="checkbox"/> Improper work method <input type="checkbox"/> Improper body position	
What have you done to correct this act?				
Supervisor's Signature: _____			Date: _____	
Supervisor's Name (Printed): _____			Office Phone: _____	

Use this form with the DWC-1 form (Employee's Claim for Worker's Compensation Benefits).

Send the original of this form to Risk Management

PERALTA COMMUNITY COLLEGE DISTRICT, 333 East 8th Street, Oakland, CA 94606