SANTA ROSA JUNIOR COLLEGE

SUPERVISOR'S REPORT OF INJURY

Fax to HR within 24hrs of injury: (707) 527-4967

Name of injured: _____

Date of injury: _____ Date reported: _____

Time of injury: _____ ☐am ☐pm Time started work: _____ ☐am ☐pm

Job title: _____

Work location: ☐ Santa Rosa ☐ PSTC Windsor ☐ Petaluma ☐ Shone Farm ☐ Other _____

Hrs. worked/day: _____ Days/week: _____ Total weekly hrs: _____

Did employee lose at least one full day of work AFTER incident?

☐Yes ☐No Date last worked: _____

If yes, has employee returned to work?

☐Yes, date returned _____ ☐ No

To your knowledge, did the employee see a physician for this injury/illness?

☐ Yes ☐ No

If yes, give name and address of physician: _____

_____

Place and location where accident or exposure occurred? _____

_____

What was employee doing when injured? _____

_____

Describe how the injury/illness occurred? _____

_____

Object or substance that directly injured employee (e.g. teeth, nails, chair, etc.): _____

_____

Describe the injury/illness (e.g. cut, strain, fracture, exposure): _____

_____

Part of the body affected (i.e. back, wrist, leg, eye): _____

Name of witnesses: _____

_____

What steps have been taken to prevent a similar accident?: _____

_____

Supervisor's Signature: _____ Phone No: _____ Date: _____

Printed Supervisor's Name: _____

FILING THIS REPORT IS NOT AN ADMISSION OF LIABILITY January 2013