SUPERVISOR'S REPORT OF EMPLOYEE INJURY

Print Name of Injured	SS#	Date of Birth	☐ Female ☐ Male

Home Address of Employee (Street Address, City, State, Zip)	Telephone # Home ___________________ Work _______________________ Cell _______________________

Job Title	Employed At: ☐ BCC ☐ COA ☐ Laney ☐ Merritt ☐ 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: ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun
Total Hrs. Normally Worked Per Week_______ (This information is very important for all hourly employees)

Did the Employee Receive Medical Treatment? ☐ Yes ☐ No (Please attach a copy of any medical documentation).	If Yes, Where? (Please include address of medical facility)

Did Employee Miss Any Full Days From Work? ☐ Yes ☐ No	Date Employee Returned to Work? _________________ ☐ Still off Work

PART OF THE BODY INJURED (Check all that apply)

☐ Head	☐ Back	☐ Finger(s)	☐ Toe(s)	☐ Part of Body, Not Specified
☐ Ear(s)	☐ Shoulder(s)	☐ Thumb(s)	☐ Foot/Feet	☐ Left
☐ Eye(s)	☐ Arm(s)	☐ Leg(s)	☐ Emotional Distress	☐ Right
☐ Mouth/Teeth	☐ Wrist(s)	☐ Knee(s)	☐ Whole Body	☐ Both
☐ Neck	☐ Hand(s)	☐ Ankle(s)	☐ Other __________	

TYPE OF INJURY

☐ Fall from heights	☐ Exposure to Infectious Substances	☐ Repetitive Motion
☐ Fall, same level	☐ Struck-against _____________	☐ Heat/Cold Exposure
☐ Struck by ________________	☐ Caught in or between objects	☐ Needle Stick
☐ Exposure to Hazardous Substances	☐ Overexertion	☐ Exposure/Contact (Electrical)
		☐ Insufficient Data

UNSAFE CONDITION (Check all that apply)

☐ Defective equipment – tools	☐ Slippery or uneven walking surface
☐ Equipment not properly guarded	☐ Faulty layout of facilities
☐ Poor working conditions (light, ventilation)	☐ Poor housekeeping
☐ Other (Specify) ______________________	

What have you done to eliminate this condition? (Attach additional sheets as needed)

UNSAFE ACT (Check all that apply)

☐ Lack of training	☐ Not using personal safety device	☐ Horseplay
☐ Not following rules	☐ Physical or mental handicap	☐ Improper work method
☐ Haste	☐ Inattention	☐ Improper body position
☐ Other (Specify) ________________		

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