

San Diego Community College District

Injury and Illness Incident and Investigation Report

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

See CCR Title 8 14300.29(b)(6)-(10)

Information about the employee:

Full Name	Date of birth	/	/	
Street	Date of hire	/	/	
City	State	Zip	Department	
Social Security #	Position			
Telephone #	Male,	Female		

Information about the physician or other health care professional:

Name of the physician or other health care professional:
 If treatment was provided away from the worksite, where was it given?

Facility:

Street:

City: State: Zip:

Was the employee treated in an emergency room? Yes No

Was the employee hospitalized overnight as an in-patient? Yes No

Information about the accident or illness:

Case number from the log _____ (To be filled in by the Risk Management Office)

Injury/Illness: Date / / Time AM PM Check if time unknown

Date Injury/Illness reported by employee / /

Time employee began work AM PM

Physical Location of Injury/Illness

Did employee leave Work? Yes No Date returned to work / /

If employee died, when did death occur? Date of death / /

What was the employee doing just before the incident occurred? Describe the activity, as well as the tools, equipment or material the employee was using. Be specific. *Examples: "Climbing a ladder while carrying roofing materials"; "Spraying chlorine from a hand sprayer"; "Daily computer key-entry."*

Were the tools, equipment or materials used by the employee at the time of the incident in good condition? Yes No If No, describe the specific deficiencies.

What happened? Explain how the injury occurred. Examples: "When the ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time".

What was the injury or illness? Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain" or "sore". Examples: "strained back"; "chemical burn, hand"; "carpal tunnel syndrome".

What object or substance directly harmed the employee? Examples: "concrete floor"; "chlorine gas"; "computer".

Were there any workplace conditions, practices or lack of protective equipment that contributed to the accident? Yes No If Yes, describe the deficiencies.

Will a new workplace Safety Rule be required? Yes No Please explain:

Was the unsafe condition, practice or equipment problem corrected immediately? Yes No
What corrective actions have been taken to prevent another occurrence?

Witnesses if available:

Name
Name

Phone number
Phone number

Supervisor/Manager (Primary Investigator):

Title

Date

Safety Officer

Title

Date

THIS FORM IS NOT TO BE FILLED OUT BY THE INJURED EMPLOYEE!

SEND A COMPLETED COPY OF BOTH PAGES OF THIS FORM TO THE RISK MANAGEMENT OFFICE, ROOM 385, PLAZA, WITHIN 24 HOURS OF THE INJURY.
PLEASE EMAIL OR FAX A COPY TO (619) 388-6898 THEN SEND THE ORIGINAL.

Orig: Risk Management Office
Copy: President / Assistant Chancellor
Copy: Business Service Office
Copy: File