Adelanto School District

11824 Air Expressway, Adelanto, CA 92301

Supervisor's Report of Injury or Illness

(Complete for All Employee-Reported Injuries)

Employer: _____ Nature of business: _____

Department: _____ Division/Location: _____

Name of injured employee: _____

Occupation: _____

Date of injury or illness: _____ Time: _____ AM _____ PM

Was medical treatment offered? Yes _____ No _____ Was treatment refused? Yes _____ No _____

Was employee given a claim form? Yes _____ No _____ Employee's Signature: _____

What type of medical treatment was given?

First aid _____ Paramedics _____ Emergency room _____

Hospitalization _____ Clinic _____ Authorized _____

Predesignated physician's name (attach form): _____

Was employee required to leave work due to this injury or illness? Yes _____ No _____ Date last worked: _____

Has employee returned to work? Yes _____ Date returned: _____ No, still off work _____

Name of person to whom the injury or illness was reported: _____

Timeliness of reporting: If the accident was not reported immediately, why not? _____

_____

Location where accident or exposure occurred: _____

_____

Was the injury or exposure witnessed? Yes _____ No _____

WITNESS INFORMATION

Name: _____ Name: _____

Address: _____ Address: _____

City/State/Zip: _____ City/State/Zip: _____

Telephone: _____ Telephone: _____

List property damage, if any: _____

_____

(continued on reverse)

Body part injured (check all that apply and indicate left and/or right):

_____ Head	_____ Upper back	_____ Finger (which?)	_____ Ankle
_____ Face	_____ Lower back	_____ Upper leg	_____ Foot
_____ Eye	_____ Arm	_____ Lower leg	_____ Toe (which?)
_____ Neck	_____ Wrist	_____ Knee	_____ Other _____

Nature of injury or illness:

_____ Scrape	_____ Burn	_____ Fracture	_____ Cold-related problem
_____ Cut	_____ Sprain/strain	_____ Skin problem	_____ Loss of consciousness
_____ Puncture	_____ Foreign body	_____ Chemical-related problem	_____ Respiratory problem
_____ Bruise	_____ Poisoning	_____ Heat-related problem	_____ Other_____

What was employee doing at the time of injury or exposure? _____

_____

Person, object or substance that directly injured employee:_____

_____

Check any of the following unsafe actions which apply:

_____ Haste/unsafe speed	_____ Improper procedure	_____ Unsafe lifting
_____ Not authorized	_____ Unsafe equipment usage	_____ Unsafe position
_____ Disregard of instructions	_____ Defective equipment/tools	_____ Running/jumping
_____ Lack of knowledge/skill/training	_____ Inattention	_____ Poor housekeeping
_____ Failure to use proper equipment	_____ Assault	_____ Act of other
_____ Inadequate protective gear	_____ Horseplay	_____ Physical handicap
_____ Carelessness	_____ Alcohol/drugs	_____ Other _____

_____ I know the injury occurred on duty. _____ I have no specific knowledge that the injury occurred on duty.

What steps have been taken or recommended to prevent a recurrence?_____

_____

_____

Comments:_____

_____

_____

_____

Supervisor's signature: _____ Date:_____