SAN DIEGO
COMMUNITY COLLEGE DISTRICT

Appendix D

# 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)

**THIS FORM IS NOT TO BE FILLED OUT BY THE INJURED EMPLOYEE!**
**CALL RISK MANAGEMENT IMMEDIATELY**.

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

## INFORMATION ABOUT THE EMPLOYEE:

Full Name:_____ Date of Birth:_____
Street Address:_____ Date of Hire:_____
City: _____ State: _____ Zip: _____ Male ◯ Female ◯
Home Telephone #:_____ Cell phone #:_____
Prefer to be reached at: Home Telephone # ◯ Cell Phone # ◯ Email_____
Campus and Department:_____
Occupation/Position Title: _____
Employment Status: Regular, Full-time ◯ Part-time ◯ Open Enrollee ◯
Regular work hours: Start _____ AM ◯ PM ◯ - End_____ AM ◯ PM ◯
Work Days: Sunday ◯ Monday ◯ Tuesday ◯ Wednesday ◯ Thursday ◯ Friday ◯ Saturday ◯

## INFORMATION ABOUT THE PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL:

Name of the physician or other health care professional:_____
Name of facility:_____ Street address:_____
City: _____ State: _____ Zip: _____ Phone:_____
Was the employee treated in an emergency room? Yes ◯ No ◯
If Yes, where:_____
Was the employee taken by ambulance? Yes ◯ No ◯
Was the employee hospitalized overnight as an in-patient? Yes No
If Yes, where:_____
Date notified: _____ Time notified:_____ AM ◯ PM ◯

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## INFORMATION ABOUT THE ACCIDENT OR ILLNESS:

Injury / IllnessDate:_____ Injury / Illness Time: ___ AM ◯ PM ◯ Time Unknown ◯
Date Injury / Illness Reported by the employee:_____Time employee began work:_____
Specific Dept/Location of where incident happened. (i.e. Biology Room G):_____
If incident happened off site, provide name of location/facility:_____
Address:_____ City:_____ State:_____ Zip:_____
Did employee leave work? Yes ◯ No ◯ Date returned to work?_____
If employee died, what date did death occur:_____ Not Applicable ◯
Date DWC-1 Claim Form was given to employee:_____

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”.)

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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 ◯ If yes, please explain:

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

**Witnesses if available**

Name:_____ Phone Number:_____

**Supervisor /Manager (Primary Investigator)**

Print Name:_____ Date:_____ Signature:_____

**SafetyOfficer**

Print Name:_____ Date:_____ Signature:_____