SANTA BARBARA COMMUNITY COLLEGE DISTRICT

**EMPLOYEE'S REPORT OF WORK INJURY/ILLNESS**

PLEASE REPORT ALL INJURIES WITHIN 24 HOURS (NO MATTER HOW TRIVIAL)

COMPLETE THIS FORM (Be sure that all areas are completely filled out.)

| | |
|---|---|
| Name of Employee:<br><br>_____<br>(Last) (First) (Middle) | K Number |
| Home Address (Number, street and city) Zip | Home Phone:<br>_(____)_____<br>Work Phone:<br>_(____)_____ |
| Sex Occupation (Regular job title, not specific activity at time of injury)<br>☐ Male<br>☐ Female _____ | Date of Birth:<br><br>_____/_____/_____<br>Month Day Year |
| Department in which regularly employed:<br><br>☐ Regular F/T-P/T ☐ Hourly ☐ Student Worker ☐ Volunteer | Date of Hire:<br><br>_____/_____/_____<br>Month Day Year |
| Where did accident or exposure occur? (Room #, building, address, city and county)<br><br>Time you began work: _____a.m._____p.m. | On Employer's Premises?<br><br>☐ Yes ☐ No |

What were you doing when injured? (Please be specific, identify tools, equipment or material you were using.)
(Use back if more space is needed) _____
_____
_____
_____

Date of Incident _____/_____/_____ Time of Day _____a.m. _____p.m.
Month Day Year

Nature of Injury/Illness (Be specific; i.e. right/left – arm/leg – scrape/cut/burn, etc) _____
_____
_____

Have you ever been treated for a similar Injury/Illness? ☐ Yes ☐ No
If yes, give date _____/_____/_____ Name and address of treating doctor_____
Month Day Year

_____

Name of immediate supervisor _____

Name(s) and address of any witness(es) to this incident:
_____
_____

What do you recommend for preventing this type of accident? (State the specific preventive measures that can be taken by employer and workers. Do not say: "By being more careful.") _____
_____

Do you require or desire medical attention at this time?

☐ Yes (If so, please notify Risk Manager directly.)

☐ No (If not, please sign here) _____

NOTE: If medical treatment is needed at a later date, please call.

☐ I have received current information regarding my benefits (please initial here) _____

I declare under penalty of perjury that the foregoing is true and correct.

Signature of employee _____Date Report Completed: _____/_____/_____
Month Day Year

**This Report must be submitted to the Risk Manager, within one working day.**

**ECOC-3 Extension 2266**