SAN MATEO COUNTY COMMUNITY COLLEGE DISTRICT

Office of Human Resources
3401 CSM Drive San Mateo, CA 94402
Tel: (650) 574-6555 Fax: (650) 574-6574

Reset Form

Injurer Injury/Illness Incident Report

Print Form

Injurer's Name: _____ Date of Injury: _____ ☐ Male ☐ Female

Campus: ☐ SKYLINE COLLEGE ☐ CSM ☐ CANADA COLLEGE ☐ CHANCELLOR'S OFFICE

Category: ☐ Permanent Employee ☐ Adjunct Faculty ☐ Short-Term/ Student Asst ☐ Visitor ☐ Student ☐ Volunteer

Home Address: _____ Date of Birth _____

Home Telephone: _____ Alternative Telephone _____ SS#: _____

Description of Incident: Time of injury/illness: _____ AM/PM Incident Location: _____

What were you doing before the incident occurred?

_____

_____

How did the injury occur (give all factors of contribution to accident/object/substance directly harmed you)?

_____

_____

What was the injury or illness (body part injured and type of injury)? _____

Witnesses Name(s): _____

Health Care:

Student Insurance Information (Student Accident Insurance is secondary):

☐ Advise student to report to health center if medical claim needs to be filed.

Health Center Care Treatment: ☐ College Nurse ☐ First Aid ☐ 911 ☐ Campus Security ☐ Other _____

Care Administered by: _____

Employment/Volunteer Health Care:
Note: Must have Pre-designated Personal Physician in writing before the injury/illness occurred.
If pre-designation did not occur, must refer injurer to District Designated Medical Facility List for medical treatment.

Pre-designated Personal Physician or Facility / Physician Where Treatment Occurred Contact Information:

Name: _____ Address: _____

Were you seen in the emergency room? _____ Were you hospitalized overnight as an in-patient? _____

If no medical treatment is needed, please select the below.

☐ I decline medical treatment at this time. Should I decide to obtain medical treatment in the future, I will notify Human Resources and/or my supervisor. I understand that my failure to do so may cause a delay, as well as possible denial of payment for any treatment.

Employment Information:

Department: _____ Supervisor Name: _____

Job Title: _____ Date of Hire: _____ Time Work Started: _____ AM/PM

Signature of Injurer: _____ **Date:** _____

Health Center Distribution: District Office, Operations, Health Center, Instructor

Please return this form to Human Resources.
This form can be used for any type of incident reporting and awareness.
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SUPERVISOR'S INJURY/ILLNESS INVESTIGATION REPORT

Campus: ☐ SKY ☐ CSM ☐ CAÑ ☐ CHANC OFFC

Employee Name:			
Department:		How Long Employed:	
Job Title:		Location of Accident:	
Date Reported:		Date & Time of Accident:	
Was Employee Sent/seen by Dr?	☐ YES ☐ NO	If Yes, where?	
Was First Aid Given?	☐ YES ☐ NO	Was Time Lost?	☐ YES ☐ NO
First Aid Given By Whom?		How Many Days?	

IDENTIFICATION OF THE ACCIDENT FACTORS

Injury and/or Damage:

Brief Description of Accident (What Happened):

Accident Type (check one)	☐ Struck By	☐ Fall	☐ Inhalation	☐ Contact With Electrical Current
	☐ Struck Against	☐ Repetitive Motion	☐ Ingestion	☐ Exposure to Temperature Extremes
	☐ Overextended	☐ Caught In / On / Between	☐ Absorption	☐ Rubbed or Abraded

Any Witnesses? Provide Name(s):

ACCIDENT CAUSES

What Specific Act was Responsible for this Accident?

What Specific Condition was Responsible for this Accident?

REASONS - Why was the Act Committed and/or Why did the Condition Exist? (please specify on the lines below)

☐ Lack of Knowledge/Experience ☐ Attitude ☐ Human Limitation ☐ Condition

CORRECTIVE ACTION

What Do You Suggest be Done to Prevent a Similar Accident?

☐ Instruction / Training ☐ Motivation / Discipline ☐ Proper Equipment Placement ☐ Repair / Eliminate ☐ Recommend to Manager

(Please Specify)

What Actions Have You Taken?

Supervisor Signature	Date	Administrator Signature	Date

PLEASE RETURN TO HUMAN RESOURCES.