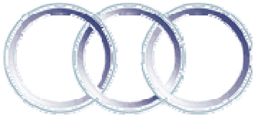


SAN MATEO COUNTY
COMMUNITY COLLEGE DISTRICT

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

Injurer's Injury/Illness Incident Report

Injurer's Name: ____________________________ Date of Injury: _______________ ☐ Male ☐ Female

Campus: ☐ SKY ☐ CSM ☐ CAÑ ☐ CHANC OFFC

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: ☐ 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:

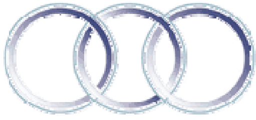
Department: ______________________________ Supervisor Name: __________________________

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.



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

SUPERVISOR'S INJURY/ILLNESS INVESTIGATION REPORT FORM

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.