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.)

<table>
<thead>
<tr>
<th>Name of Employee:</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Last)</td>
<td>(First)</td>
</tr>
<tr>
<td>Home Address (Number, street and city)</td>
<td>Zip</td>
</tr>
<tr>
<td></td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>Occupation (Regular job title, not specific activity at time of injury)</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td>Date of Hire:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>/ / /</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Department in which regularly employed:</th>
<th>Date of Hire:</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Where did accident or exposure occur? (Room #, building, address, city and county)</th>
<th>On Employer’s Premises?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time you began work: _________a.m._________p.m.</td>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

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 Risk Manager, Administrative Services within one working day.
Room A-120 Extension 2266