SANTA BARBARA COMMUNITY COLLEGE DISTRICT
SUPERVISOR’S REPORT OF EMPLOYEE INJURY OR ILLNESS

Name of Injured: ________________________________  Soc. Sec. No: ________________________________

Department Title: ______________________________  Job Title: ________________________________

Date of Hire: ____________________ usually works ______ hrs/day _______ days/wk _________ hrs/wk  Salary/Wage: ____________________

Employment status: ____________________ Any other employment outside SBCC? ____________________

Home address: ________________________________  Home Phone: ________________________________

Date of injury: ___________ Day of week: _______ Time of day: _______ a.m. Time employee began work _______ p.m.

Date last worked: ___________  Date returned to work: ___________ -OR-  □ Still off work  □ No lost time

Date reported to supervisor: ___________  Time: _______ p.m.  Claim form to employee: Y/N ________

Specific injury and body part affected or illness: ____________________________________________

(Example: Cut right hand, first degree burns on left arm, etc.)

Where did injury happen: ________________________________  Building room -or- Street address, City if off campus

What equipment, tools, materials, chemicals, was employee using? ________________________________

What specific activity/task was the employee performing when injury/illness occurred? ____________________

Write details of how the incident occurred, state facts: ____________________________________________

Did injured have medical aid?  □ Yes  □ No  If yes, where? ________________________________

□ First Aid Only  □ Campus Health Center Nurse

□ Doctor (Complete name/address): ________________________________

□ Hospital Admission (Name/address): ________________________________

Names of witness(es) and/or persons performing first aid / addresses / phone numbers: ________________________________

__________________________________________________________

Supervisor’s Signature  Date  Ext: ____________________

ANY INJURY OR ILLNESS MUST BE REPORTED TO THE IMMEDIATE SUPERVISOR AND THE ADMINISTRATIVE SERVICES MANAGER IMMEDIATELY. THIS REPORT MUST BE SUBMITTED TO THE ADMINISTRATIVE SERVICES MANAGER WITHIN ONE WORKING DAY, ROOM A-120, EXTENSION 2266.

-See instructions on Reverse Side-

file: Supervisor’s Report
revised 09/15/08