Great Schools Successful Kids

FULLERTON SCHOOL DISTRICT

SUPERVISOR'S REPORT OF EMPLOYEE INJURY
Privileged Attorney–Client Work Product
(This form is to be completed by the employee's supervisor.)

INJURED EMPLOYEE: _____ **JOB TITLE:** _____ **DATE OF HIRE:** _____

HOME ADDRESS: _____ **CITY/ST/ZIP:** _____

PHONE: _____ **DATE OF BIRTH:** _____

SUPERVISOR: _____ **ASSIGNED DEPARTMENT:** _____

LOCATION WHERE INCIDENT OCCURRED: ☐ PLAYGROUND ☐ CLASSROOM ☐ KITCHEN ☐ OFFICE **OTHER:** _____

HOURS WORKED PER WEEK: _____ **(SCHEDULE: M _____ T _____ W _____ TH _____ FRI _____)**

DATE OF ACCIDENT: _____ **TIME:** _____AM/PM **DATE REPORTED:** _____ **TIME:** _____AM/PM

START TIME ON DAY OF ACCIDENT: _____ AM/PM

AT TIME OF INCIDENT EMPLOYEE WAS: ☐ DIRECTLY SUPERVISED ☐ INDIRECTLY SUPERVISED

☐ PERFORMING NORMAL DUTIES ☐ ON BREAK ☐ ENTERING/LEAVING FACILITY ☐ OTHER ASSIGNED DUTIES

IDENTIFY CAUSATION (MARK WITH X)

Slip and Fall	Struck By Object	Lifting or Moving	Caught In or Between	Bite	Object in Eye	Repetitive Motion	Student Behavior	Other

IDENTIFY BODY PARTY (MARK WITH X)

Head	Face	Back	Foot	Hand	Finger	Leg	Wrist	Other

DESCRIBE THE ACTIONS LEADING UP TO THE INJURY:

_____

_____

_____

DESCRIBE ACTIONS NEEDED TO PREVENT A SIMILAR INJURY:

_____

_____

_____

_____

DID EMPLOYEE GO TO INDUSTRIAL CLINIC? YES ☐ **NO** ☐ **NAME OF CLINIC:** _____

DID EMPLOYEE RETURN TO WORK? YES ☐ **NO** ☐ **DATE RETURNED TO WORK:** _____

NAME OF WITNESS (IF APPLICABLE): _____

I HAVE RECEIVED WORKERS' COMPENSATION BENEFITS INFORMATION

EMPLOYEE SIGNATURE: _____ **Date:** _____

PRINCIPAL/SUPERVISOR SIGNATURE: _____ **Date:** _____

PLEASE FAX THIS FORM IMMEDIATELY TO WORKERS' COMPENSATION 714-446-1068