

# SUPERVISOR'S CLAIM & SAFETY REPORT OF ACCIDENT

1 Name of Injured _____		Social Security Number _____		CWID _____	
Date of Birth _____		Sex <input type="checkbox"/> Female <input type="checkbox"/> Man		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Legal Separation	
Home Phone Number _____		Alternate Phone Number _____		Email Address _____	
Home Address _____					
2 Date of Injury or Illness _____ (mm/dd/yyyy)		Time of Day _____ a.m. _____ p.m.		Was Employee Unable to Work on Any Day After Injury? <input type="checkbox"/> Yes, Date (mm/dd/yyyy) _____ <input type="checkbox"/> No	
On Employer's Premises? <input type="checkbox"/> Yes <input type="checkbox"/> No					
3 Has Employee Returned to Work? <input type="checkbox"/> Yes, Date Returned _____ <input type="checkbox"/> No, Still Off Work					
Did Employee Die? <input type="checkbox"/> Yes, Date _____					
Wages \$ _____ Per Week Full Time? <input type="checkbox"/> Yes <input type="checkbox"/> No Occupation _____					
4 Accident Cause Check Appropriate Boxes		7 What happened? _____		Describe what took place or what caused you to make this investigation	
STRUCK AGAINST <input type="checkbox"/>		_____		_____	
STRUCK BY <input type="checkbox"/>		_____		_____	
FALL ON SAME LEVEL <input type="checkbox"/>		_____		_____	
CAUGHT IN OR BETWEEN <input type="checkbox"/>		_____		_____	
OVEREXERTION <input type="checkbox"/>		Why did it happen? _____		Get all the facts by studying the job and and situation involved question by use of WHY-WHAT-WHERE-WHEN-WHO-HOW	
CONTACT WITH TEMPERATURE <input type="checkbox"/>		_____		_____	
EXTREMES <input type="checkbox"/>		_____		_____	
LIFTING <input type="checkbox"/>		_____		_____	
OTHER (SPECIFY) <input type="checkbox"/>		_____		_____	
5 Description of Injury Check Appropriate Boxes		What Should Be Done? _____		Determine Which of The 12 Items Under EMP	
SIDE OF BODY <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT		_____		Require Additional Attention	
ABRASION <input type="checkbox"/> BRUISE <input type="checkbox"/>		_____		EQUIPMENT <input type="checkbox"/> MATERIAL <input type="checkbox"/> PEOPLE <input type="checkbox"/>	
SWELLING <input type="checkbox"/> SPRAIN <input type="checkbox"/>		_____		Check Appropriate Boxes	
PUNCTURE <input type="checkbox"/> ILLNESS <input type="checkbox"/>		_____		ARRANGE <input type="checkbox"/> PLACE <input type="checkbox"/> PLACE <input type="checkbox"/>	
DISLOCATION <input type="checkbox"/> CUT <input type="checkbox"/>		_____		USE <input type="checkbox"/> HANDLE <input type="checkbox"/> TRAIN <input type="checkbox"/>	
FRACTURE <input type="checkbox"/>		_____		MAINTAIN <input type="checkbox"/> PROCESS <input type="checkbox"/> LEAD <input type="checkbox"/>	
OTHER (SPECIFY) <input type="checkbox"/>		_____		_____	
6 Part of Body Injured Check Appropriate Boxes		What Have You Done Thus Far? _____		Take or Recommend Action Depending Upon	
ANKLE <input type="checkbox"/> HIP <input type="checkbox"/>		_____		Your Authority Follow Up --	
ARM <input type="checkbox"/> KNEE <input type="checkbox"/>		_____		Was Action Effective?	
BACK <input type="checkbox"/> LEG <input type="checkbox"/>		_____		_____	
CHEST <input type="checkbox"/> LIP <input type="checkbox"/>		_____		_____	
MOUTH <input type="checkbox"/> CHIN <input type="checkbox"/>		_____		_____	
EAR <input type="checkbox"/> NECK <input type="checkbox"/>		_____		_____	
SHOULDER <input type="checkbox"/> NOSE <input type="checkbox"/>		How Will This Improve Operations? _____		Objective:	
FINGER <input type="checkbox"/> EYE <input type="checkbox"/>		_____		Eliminate Job Hindrances	
FOOT <input type="checkbox"/> TOOTH <input type="checkbox"/>		_____		_____	
HAND <input type="checkbox"/> WRIST <input type="checkbox"/>		_____		_____	
HEAD <input type="checkbox"/>		_____		_____	
OTHER (SPECIFY) <input type="checkbox"/>		8 Name and Address of Physician/Hospital _____		_____	
9 Employer Name: Foothill- De Anza Community College District		9A Location Code _____		Witnesses _____	
10 Mailing Address: 12345 El Monte Rd, Los Altos Hills, CA 94022		10A Phone Number _____		_____	
11 Nature of Business: Education		12 Date of Hire (mm/dd/yyyy) _____		_____	

Remarks \_\_\_\_\_

Equipment Failure/Malfunction (Describe) \_\_\_\_\_

Non-Employee Involved (Name/Address/Phone) \_\_\_\_\_

Automobile Accident (Driver/License Plate) \_\_\_\_\_

Unusual Circumstances \_\_\_\_\_

Completed by (Type or Print) \_\_\_\_\_ Date Reported by Employee (mm/dd/yyyy) \_\_\_\_\_

Signed Supervisor \_\_\_\_\_ Date (mm/dd/yyyy) \_\_\_\_\_