San Diego Community College District
Injury and Illness Incident and Investigation Report

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.
See CCR Title 8 14300.29(b)(6)-(10)

THIS FORM IS NOT TO BE FILLED OUT BY THE INJURED EMPLOYEE!

CALL RISK MANAGEMENT IMMEDIATELY.
WITHIN 24 HOURS OF THE INJURY, SEND A COMPLETED COPY OF BOTH PAGES OF THIS FORM TO RISK MANAGEMENT, ROOM 385, DISTRICT OFFICE.
PLEASE EMAIL TO SDCCDRISKMANAGEMENT@SDCCD.EDU
OR FAX A COPY TO (619) 388-6898. THEN SEND THE ORIGINAL.

INFORMATION ABOUT THE EMPLOYEE:

Full Name: ______________________________ **Date of Birth:** ______________
Street Address: ______________________________ **Date of Hire:** ______________
City: ______________ **State:** ______ **Zip:** ______ ☐ **Male** ☐ **Female**
Home Telephone #: ______________ **Cell phone #:** ______________
Prefer to be reached at: ☐ **Home Telephone #** ☐ **Cell Phone #** **Email:** ______________
Campus and Department: ______________________________
Occupation/Position Title: ______________________________
Employment Status: ☐ **Regular, Full-time** ☐ **Part-time** ☐ **Open Enrollee**
Regular work hours: Start ________ ☐ **AM** ☐ **PM End** ________ ☐ **AM** ☐ **PM**
Work Days: ☐ **Sunday** ☐ **Monday** ☐ **Tuesday** ☐ **Wednesday** ☐ **Thursday** ☐ **Friday** ☐ **Saturday**

INFORMATION ABOUT THE PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL:

Name of the physician or other health care professional: ______________________________
Name of facility: ______________________ **Street address:** ______________________
City: ______________ **State:** ______ **Zip:** ________ **Phone:** ______________
Was the employee treated in an emergency room? ☐ **Yes** ☐ **No**
If Yes, where: ______________________________
Was the employee taken by ambulance? ☐ **Yes** ☐ **No**
Was the employee hospitalized overnight as an in-patient? ☐ **Yes** ☐ **No**
If Yes, where: ______________________________
If hospitalized, was Risk Management immediately notified? ☐ **Yes** ☐ **No**
Date notified: ____________ **Time notified:** ____________ ☐ **AM** ☐ **PM**

INFORMATION ABOUT THE ACCIDENT OR ILLNESS:

Injury / Illness Date: ____________ **Injury / Illness Time:** ________ ☐ **AM** ☐ **PM** ☐ **Time Unknown**
Date Injury / Illness Reported by the employee: __________ **Time employee began work:** ____________
Specific Dept/Location of where incident happened. (i.e. Biology Room G)**:** ______________________
If incident happened off site, provide name of location/facility: ______________________
Address: ______________________ **City:** ______________ **State:** ______ **Zip:** ________
Did employee leave work? ☐ **Yes** ☐ **No** **Date returned to work?** ______________
If employee died, what date did death occur: ______________ ☐ **Not Applicable**
Date DWC-1 Claim Form was given to employee: ______________

What was the employee doing just before the incident occurred? (Describe the activity, as well as the tools, equipment or material the employee was using. Be specific. *Examples:* “Climbing a ladder while carrying roofing materials”; “Spraying chlorine from a hand sprayer”; “Daily computer key-entry”.)

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Were the tools, equipment or materials used by the employee at the time of the incident in good condition?
☐ **Yes** ☐ **No** **If No, describe the specific deficiencies: ______________________________**
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What happened? (Explain how the injury occurred. *Examples*: ”When the ladder slipped on wet floor, worker fell 20 feet”; “Worker was sprayed with chlorine when gasket broke during replacement”; “Worker developed soreness in wrist over time”.)

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What was the injury or illness? (Tell us the part of the body that was affected and how it was affected; be more specific than “hurt”, “pain” or “sore”. *Examples*: “strained back”, “chemical burn, hand”; “carpal tunnel syndrome”.)

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What object or substance directly harmed the employee? (*Examples*: “concrete floor”; chlorine gas”; “computer”.)

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Were there any workplace conditions, practices or lack of protective equipment that contributed to the accident? ☐ **Yes** ☐ **No** **If yes, describe the deficiencies: ______________________________**
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Will a new workplace Safety Rule be required? ☐ **Yes** ☐ **No** **If yes, please explain: ____________**
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Was the unsafe condition, practice or equipment problem corrected immediately? ☐ **Yes** ☐ **No** ☐ **N/A**
What corrective actions have been taken to prevent another occurrence? ______________________
____

Witnesses if available:
Name: ______________________________ Phone Number:________________________

Supervisor / Manager (Primary Investigator):
Print Name: ______________________________ Date: ______________
Signature: ______________________________

Safety Officer
Print Name: ______________________________ Date: ______________
Signature: ______________________________

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