SCCSIG

SANTA CLARA COUNTY SCHOOLS' INSURANCE GROUP
REPORT OF EMPLOYEE INCIDENT/INJURY

DISTRICT _____ **SCHOOL NAME/SITE** _____

PART 1: TO BE COMPLETED BY THE EMPLOYEE

Name: _____ Emp. ID# _____

Home Address: _____ Phone: _____ Sex: ☐ F ☐ M

Job Title: _____ Department: _____

To whom did you report this incident? _____ Date of Injury: _____

Time of incident: _____ ☐ AM ☐ PM Time you begin work: _____ ☐ AM ☐ PM

Were you unable to work as a result of this injury? ☐ Y ☐ N If yes, date last worked _____

Have you returned to work? ☐ Y ☐ N If yes, date returned _____

Body part injured (Be Specific) _____ Have you gone or are you planning to go to a doctor? ☐ Y ☐ N

If yes, state name and address of doctor: _____

Date you reported incident: _____ Location of incident: _____

How did incident occur? Be specific and detailed:

_____

Employee's Signature: Date:

PART II: TO BE COMPLETED BY SUPERVISOR/PRINCIPAL

TYPE OF INCIDENT: (Check one) ☐ Injury ☐ Illness ☐ Near Miss

Incident Date: _____ Where did the incident occur? _____

Did incident occur on school premises? ☐ Y ☐ N Under school jurisdiction? ☐ Y ☐ N Safety Rule(s) violated? ☐ Y ☐ N

Was employee working within his/her job description? ☐ Y ☐ N Date employee reported incident: _____

Describe the incident (How, why and what happened. Include task being performed, step by step detail of incident, and tool or object involved)

What caused the incident? _____

Name(s) of witness(es) & phone #'s:

Describe immediate corrective action: _____

Date immediate corrective action was complete: _____ By whom: _____

Describe long term corrective action: _____

Estimated date long term corrective action will be completed: _____ By whom: _____

Additional comments:

_____

Supervisor's / Principal's signature: Date:

Revised 01/18