Lucia Mar Unified School District **EMPLOYEE ACCIDENT REPORT**
602 Orchard Street, Arroyo Grande, CA 93420

To be completed by employee:

Name: _____ Birth Date: _____ SS#: _____

Home Address: _____ Phone #: _____

Job Title: _____ Time Begin Work: _____ Date of Hire: _____

Site Name: _____ Date of Injury/Illness: _____ Time of Day: _____ AM/PM

DO YOU WISH TO SEEK MEDICAL TREATMENT AT THIS TIME: ☐ **YES** ☐ **NO**

IF YES, NAME AND PHONE OF ATTENDING PHYSICIAN: _____
I understand that I may see my own doctor only if a physician designation is on file with the District.

WHAT WAS EMPLOYEE DOING WHEN INJURED: (BE SPECIFIC) _____

_____

_____

HOW AND WHERE DID INJUR/ILLNESS OCCUR? (DESCRIBE SEQUENCE OF EVENTS. USE SEPARATE SHEE IF NECESSARY.)

_____

_____

SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED. (SECOND DEGREE BURN TO RT ARM, TWISTED LEFT ANKLE, STRAINED LOWER BACK, ETC.) _____

_____

EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED. (I.E. LADDER, PRESSURE WASHER, DRILL, ALL PURPOSE CLEANER, ETC.) _____

_____

_____

WAS THERE A WITNESS TO ACCIDENT? ☐ **YES** ☐ **NO**

WAS ANOTHER PERSON RESPONSIBLE? ☐ **YES** ☐ **NO**

IF YES TO EITHER QUESTION, LIST PERSON'S NAME, PHONE NUMBER AND ANY AVAILABLE DETAILS.

_____

_____

I hereby certify under penalty of perjury that all information contained herein is true and correct to the best of my knowledge.

Employee Signature: _____ **Date: _____**

SUPERVISOR MUST COMPLETE BACK

Employee Name: _____ Date of Injury: _____

To be completed by supervisor:

WHO REPORTED THIS TO YOU? WHAT DID THEY SAY OCCURRED? _____

_____

_____

_____

_____

WHAT DID YOU SEE AND WHEN DID YOU SEE IT? (DESCRIBE SCENE OF ACCIDENT IN DETAIL) _____

_____

_____

_____

_____

DO YOU KNOW OF ANY WITNESSES? IF SO, PLEASE LIST. _____

_____

WAS SAFETY COORDINATOR CONTACTED? IF SO, WHEN? _____

Supervisor Signature: _____ **Date:** _____