

Santa Barbara County Schools - Self Insured Program For Employees (SIPE)
Employee's and Supervisor's Industrial Incident Report - Page 1 of 2

(If handwritten, please print clearly. Forward page 2 to employee's supervisor)

District [] Today's Date []

Employee's Report

(to be completed by employee, employee's designee or by district claims representative)

Employee Name [] Social Security Number [] Date of Birth []

Home Address [] Home Phone []

Sex [] Male [] Female Job Title [] Date of Hire []

Usual Work Hours hrs/day [] days/wk [] Total hrs/wk []

Employment Status [] Regular Full-Time [] Part-Time [] Temporary [] Seasonal

[] Gross Wages/Salary \$ [] per []

Other payments not reported as wage/salary (e.g. tips, meals, lodging, overtime, bonuses) [] Yes \$ [] per []

Worksite/Program [] Employee's Supervisor []

Date of Illness/Injury [] Time of Day [] Time Started Work Shift []

Description of Injury or Exposure (sprain, fracture, skin rash, etc.) []

Where did incident occur? (include address if other than primary worksite) []

On Employer's premises? [] Yes [] No

What were you doing at time of incident? []

How did the incident occur? (please describe fully the events that resulted in injury or exposure; specify object or exposure that directly produced injury or illness)

Was another person responsible? [] Yes [] No Name []

Name(s) of witnesses, if any []

If seen by a doctor, give name, address, phone and fax number of doctor []

If hospitalized, give name, address, phone and fax number of hospital []

Have you missed a shift or day of work due to this condition? [] Yes [] No

Have you received care beyond first aid for this conditions? [] Yes [] No

Have you been provided with a claim form? [] Yes [] No

Have you been provided a "Facts for Injured Workers" brochure since this incident? [] Yes [] No

Completed by [] Relationship to Employee [] Date []

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(If handwritten, please print clearly)

Employee Name _____ District _____
Date of Injury/Illness _____ Job Title _____
Brief Description of injury or exposure (sprain, fracture, skin rash, etc.) _____

Supervisor's Review

(Please investigate casual factors to prevent reoccurrence)

What was the employee doing when injured or exposed? _____
Object or substance that directly injured or exposed employee? _____
Was Employee able to work after injury or exposure? Yes No Time and Date last worked _____
Has Employee returned to work? Yes No Date Returned _____
Have you obtained information regarding the injury or exposure from witnesses? Yes No
Was there a safety hazard involved in this incident? Yes No
Has the safety hazard or unsafe condition been corrected? Yes No

If Yes, explain action taken: _____
How could injury or exposure have been prevented? _____
What action have you taken to prevent reoccurrence? _____

Supervisor's Name _____ Phone Number _____
Supervisor's Signature _____ Date _____

Safety Committee Review

Factors causing or contributing to this injury or exposure? _____

This Injury or exposure was Preventable Non-Preventable

Rationale/Comments _____

Safety Director _____ Date _____

District Safety Committee Review _____ Date _____