NORTH ORANGE COUNTY
COMMUNITY COLLEGE DISTRICT

MANAGER'S INJURY/ILLNESS/ INCIDENT REPORT

This form must be completed within 24 hours of any incident, accident, or injury / illness. **IF the injury is considered more than a First Aid , the employee must be given a Workers Compensation claim form within 24 hours of the manager's knowledge**. All accidents and incidents should be investigated no matter how minor, since the same condition(s) that caused a minor incident could lead to a major accident/injury.

Confidential

Injured Employee Name:_______________________________________ Sex: _____ Campus/site: ___________________

Job Title:___________________________ Department: ___________________ Length of Employment: ________________

Date of Injury or onset of illness: ___________ Exact Location of Injury/Incident:_________________________________

Date Employer first knew of the injury: ___________ Date claim form was provided to the employee: ___________
Medical attention employee required as a result of injury/illness: First Aid, (if so, administered by whom:_________)

Occupational Health Service Emergency Room Other (specify) ______________________________________

Describe nature of injury/illness and part of the body affected: (i.e., sprained left knee; strained lower back,etc.):

____

Full circumstances of the incident (if injury, please describe the work being performed at the time of the injury and include as much details as possible):

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Were the actions of the employee part of his/her normal job duties? _______ If no, please explain below:

____

Names and work phone numbers of witnesses, if any: a) ____
b) ____

What symptoms were reported to you as industrial accident/illness? ____
Do you agree that the injury occurred as reported? _____________________
Did the injury occur during the course and scope of his/her duty? ______________

What unsafe acts were performed? (Include rules violated, if any) ____

Fundamental Cause of Incident: ____

What has been done or is recommended to prevent recurrence of a similar incident? _________________________

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Date Completed: ___________________________ **Phone Number of Manager** _____________________________

Manager's Name ____________________________ **Manager's Signature**_________________________________

Date Reviewed by Department Head ____________ **Name of Department Head** __________________________

Distribution: Original – District Director, Risk Management
Copy – Manager

Reviewed: 8/1/15