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".)

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:**

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".)

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".)
Right ring finger was caught on foldable dolly

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

Were there any workplace conditions, practices or lack of protective equipment that contributed to the accident? ☐ **Yes** ☒ **No** **If yes, describe the deficiencies:**

Will a new workplace Safety Rule be required? ☐ **Yes** ☒ **No** **If yes, please explain:**

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: