**RIALTO UNIFIED SCHOOL DISTRICT**

**SUPERVISOR’S REPORT OF WORK INJURY/ILLNESS**

**Report all Injuries within 24 hours**

**To be completed by Supervisor**

**(Form must be completely filled out)**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name of Employee: | | | | | | | | | | | | | |
| (First) | | | (MI) | (Last) | | | | | | | | | |
| Home Address (Number, Street, City, Zip Code): | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| Employee Number: | | | Date of Birth: | | | | | | | | Phone# |  | |
|  | | | Month: | | Day: | | Year: | | | |  |  | |
| Sex: |  | Occupation: |  | | | | | | | | | | |
| Male |  | Department/Site Assigned To: | | | | | | | | | | | |
| Female |  |  | | | | | | | | | | | |
| Date of Hire: | | |  | | | On Employer's Premises? | | | | | | | |
| Month: | | Day: | Year: | | | Yes: | |  |  | No: | |  |  |
| Where did Incident or exposure Occur? (Address, City, and County) | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| Date of Injury/Illness: | | | Time of Incident: | | | | | Shift Start Time: | | | | | |

How did incident or exposure occur? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened and how it happened. (Please use separated sheet if necessary.)

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Object or substance that directly injured employee (e.g., the machine employee struck or which struck him, the vapor or poison inhaled or swallowed, the chemical that irritated his skin; in cases of strain, the object he was lifting, pulling, etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Nature of injury/Illness (Please be specific: Identify part(s), of body, e.g., right/left, lower/upper, and type of injury e.g., sprain or laceration.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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|  |  |
| --- | --- |
| If seen by a doctor, name and address of physician: | If hospitalized, name and address of hospital: |
| Name: | Name: |
| Address | Address |

Has employee returned to work? □ Yes □ No

Was employee unable to work on any day after injury? □Yes, date last worked: \_\_\_\_\_\_\_\_\_\_ □ No

Was another person responsible? □Yes □ No; Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name address, phone# of any witness(es): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Comments: (add anything you feel is important regarding the acceptance or denial of the claim.)

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Supervisor’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_