

Employee Injury Report

Sonoma County Office of Education

Instructions: This form is to be completed by the employee's department supervisor **immediately upon receiving notification of a job-related injury/illness/exposure, and the employee is to be instructed to call the RESIG Nurse at 707-836-7457.** Filing of this form is not an admission of liability. Completed forms, and/or inquiries, should be directed to the Human Resources Analyst. **If injury results in a death, serious disfigurement, bone fractures/breaks, or hospitalization for more than observation, contact Cal/OSHA at 707-649-3700 within 8 hours of knowledge.**

Employee's Name: _____ Date of Birth: _____

Home Address (Include City & Zip): _____

Home Phone: _____ Cell Phone: _____ Sex: M F

Department/Program: _____ Occupation/Title: _____

Name of Worksite & Address: _____ Work phone: _____

Date Injury/Illness/Exposure Occurred: _____ Hour: _____ a.m. p.m.

Date Injury/Illness/Exposure Reported to Supervisor: _____ Hour: _____ a.m. p.m.

Describe the injury/illness/exposure as reported to you (describe specific body part(s) affected, e.g., left hand, lower back, right knee, etc.):

Location where injury/illness/exposure occurred (e.g., kitchen, playground, etc.): _____

Equipment, materials, or chemicals employee was using when injured: _____

Name of Witness: _____

EMPLOYEE WAS INSTRUCTED TO CALL THE RESIG NURSE AT 707-836-7457 on Date: _____ Time: _____ a.m. p.m.

SUPERVISOR'S INVESTIGATION OF OCCUPATIONAL INJURY/ILLNESS/EXPOSURE

***** IMPORTANT - IN ACCORDANCE WITH SB198 THE SUPERVISOR'S INVESTIGATION MUST BE COMPLETED *****

(1) Were Safe Work Practices followed? YES NO
If not, explain _____

((2) Was an unsafe condition the cause of the incident? YES NO
If yes, describe unsafe condition _____

Was unsafe condition corrected? YES NO If not, what interim actions have been taken to prevent similar occurrence?

(3) Will an additional Safe Work Practice be needed to avoid future incidents? YES NO
If yes, describe _____

IF INJURY IS RELATED TO A BLOODBORNE PATHOGENS EXPOSURE, PLEASE PROCEED TO QUESTION (4)

(4) If a Bloodborne Pathogens Exposure, please answer the following questions.
(a) Has employee completed the Hepatitis B vaccination series? YES IN PROGRESS NO
If yes, date vaccination series completed: _____ Vaccination administered by: _____
If in progress, indicate most recent dosage and date received: 1ST Date: _____ 2ND Date: _____
If no, has employee been notified that the vaccination series should be initiated within 24 hours of the exposure incident? YES NO

(b) Has employee's blood been tested? YES NO
If yes, date of testing: _____ Testing administered by: _____
If no, explain _____

(c) What personal protective equipment was being used at time of exposure? _____

(d) Has the source individual been identified? YES NO If yes, individual's name _____

(e) Has consent been obtained for blood testing of the source individual? YES NO
If no, explain _____

(f) Has the source individual's blood testing been completed? YES NO
If yes, date of testing: _____ Testing administered by: _____
If no, explain _____

(g) Name of SCOE nurse to contact for information regarding exposure: _____ Phone No. _____

CERTIFICATION: TO THE BEST OF MY KNOWLEDGE AND BELIEF, THIS INFORMATION IS TRUE AND REFLECTS THE FACTS

Supervisor's Name (please print): _____ Date: _____

Supervisor's Signature: _____ Phone No.: _____

TO BE COMPLETED BY THE HUMAN RESOURCES ANALYST

W/C Claim Report Only Date of Hire _____ Annual Salary _____ Months/Checks per Year _____ / _____

Employee's Regular Hours: Hours per Day _____ Days per Week _____ Hours per Week _____ Days per Year _____