



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 THIS
THREE PAGES FORM TO RISK MANAGEMENT, ROOM 385, DISTRICT OFFICE.
PLEASE EMAIL TOSDCCDRISKMANAGEMENT@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: _____
Date notified: _____ Time notified: _____ AM ☐ PM ☐

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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".)

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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: _____