

REPORT OF INDUSTRIAL INJURY
MCCCD Employee & Supervisor

Employee's Information

Employee Name: _____ Last, First, M.I.	Employee I.D.#: _____
Job Title: _____	Campus: _____
Department: _____	Department I.D.#: _____
Employee's Phone #: _____	Supervisor: _____
Work Schedule: Begins Shift at _____ <input type="checkbox"/> am <input type="checkbox"/> pm	Ends Shift at: _____ <input type="checkbox"/> am <input type="checkbox"/> pm
<input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday	

Injury/Accident

Date of Accident: _____	Time: _____ <input type="checkbox"/> am <input type="checkbox"/> pm
Date Accident was Reported: _____	Time: _____ <input type="checkbox"/> am <input type="checkbox"/> pm
Medical Attention: <input type="checkbox"/> No <input type="checkbox"/> Yes If, yes where: <input type="checkbox"/> Concentra <input type="checkbox"/> US Health Works <input type="checkbox"/> Emergency Room	
Address where the accident occurred: _____ Number & Street City State Zip Code	
Location where the accident occurred: <input type="checkbox"/> Inside <input type="checkbox"/> Outside Building/Department _____	
How did the accident occur: _____ _____	
What object and or substance harmed the employee: _____ _____	
Part of body affected: _____ <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Laceration <input type="checkbox"/> Scrape <input type="checkbox"/> Bruising <input type="checkbox"/> Broken bone(s) <input type="checkbox"/> No Visible signs of injury but has pain <input type="checkbox"/> Other: _____	
Part of body affected: _____ <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Laceration <input type="checkbox"/> Scrape <input type="checkbox"/> Bruising <input type="checkbox"/> Broken bone(s) <input type="checkbox"/> No Visible signs of injury but has pain <input type="checkbox"/> Other: _____	
What was the employee doing just before the accident occurred: <input type="checkbox"/> On Break <input type="checkbox"/> Traveling <input type="checkbox"/> Performing job duties,	
Description of job duties being performed: _____ _____ _____	
<input type="checkbox"/> Other: _____ _____	

Was any other person(s) affected by this accident: No Yes If, yes please complete the following: Name(s), employee ID, and Contact phone number: _____

Please attach a copy of their Industrial Injury Report.

Where there any witness to the accident: No Yes If, yes please complete the following: Name(s), employee ID, and Contact phone number: _____

If validity of claim is doubted, state reason: _____

Was College Safety contacted: Yes No

Was a College Safety report completed: Yes No

Employee's Name: _____
Print

*Signature/Date

Phone#

Supervisor's Name: _____
Print

*Signature/Date

Phone#

Person completing this form:

Print

*Signature/Date

Phone#

***Please do not hold up report due to signatures. Process this document within 24 hours of the accident with your college safety department and or the Human Resources department.**

Original – Compensation/Employee Benefits Copy - Supervisor Copy – College Safety. Copy – College HR

Date Received By Campus: _____

Date Received By District: _____