

OSHA Inspection No.
OSHA Case No.

Incident No. (From Sheriff)
TPA Case No. (From TPA Files)

**LOS ANGELES COMMUNITY COLLEGE DISTRICT
SUPERVISOR'S REPORT OF EMPLOYEE INJURY OR ILLNESS**
Page 1 of 2

NOTE: This form should be completed and sent to the District Workers' Compensation Office within two- (2) days of the reported injury.

SECTION I: ADMINISTRATIVE

COLLEGE/LOCATION		DEPT. / DIV.	
EMPLOYEE NAME		POSITION CLASSIFICATION	
DATE AND TIME OF INJURY OR ILLNESS		DATE AND TIME SUPERVISOR KNEW OF EMPLOYEE INJURY OR ILLNESS	
INCIDENT LOCATION		Body Part(s)	

SECTION II: EMERGENCY TREATMENT

TYPE OF TREATMENT RENDERED (✓)	NAME(S) OF FIRST AID RESPONDERS, MEDICAL PROFESSIONALS, OR EMERGENCY TREATMENT PROVIDERS	BLOODBORNE PATHOGENS EXPOSURE INCIDENT? (✓) <input type="checkbox"/> NO <input type="checkbox"/> YES <i>IF YES, SPECIFY ROUTE OF ENTRY BELOW</i>	NAME(S) OF WITNESSES TO THE OCCUPATIONAL INJURY OR ILLNESS
<input type="checkbox"/> FIRST AID (SELF ADMIN)		<input type="checkbox"/> INGESTION	
<input type="checkbox"/> FIRST AID by EMPLOYEES or MEDICAL PROFESSIONAL		<input type="checkbox"/> INHALATION	
<input type="checkbox"/> TREATMENT by MEDICAL PROFESSIONAL		<input type="checkbox"/> PARENTERAL (Injection)	
<input type="checkbox"/> EMERGENCY TREATMENT by MEDICAL PROFESSIONAL		<input type="checkbox"/> ABSORPTION	

REFERENCE: 8CCR13203

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SECTION III: Type of Incident (check all that apply)

- Illness
- Injury
- Off Campus/Work Location
- Other: _____
Specify Other Type of Incident

SECTION IV: Cause of Injury or Illness

- Horseplay
- Unsafe work practice
- Machine or Equipment
- Housekeeping
- Ergonomics
- Lack of Training
- Ventilation Systems (Indoor Air Quality)
- Other: _____
Specify Other Cause

SECTION V: Corrective Action Taken to Prevent Recurrence

- Maintenance Service Request (Facilities Doc. Number)
- Procedure Revision
- Signage
- Remove Faulty Equipment/Furniture
- Ergonomic Assessment
- Employee/Staff Training
- Other: _____
Specify Other Corrective Actions

Notes / Description
Notes/Description
Notes/Description

REFERENCE: 8CCRJ3203

SECTION VI: Additional Investigation Information *(Attach additional sheets as necessary)*

SECTION VII: Closure & Approval

Supervisor (Print Name)			Supervisor (Signature/Date)		
Supervisor (Telephone Number)		EXT.	Administrator (Signature/Date)		

REFERENCE: 8CCRJ3203

**LOS ANGELES COMMUNITY COLLEGE DISTRICT
SUPERVISOR'S REPORT OF EMPLOYEE INJURY OR ILLNESS
CONTINUATION SHEET**
(Optional)

Section Number	Notes/Description
I	
II	
III	
IV	
V	
VI	