COLLEGE OF MARIN

MARIN COMMUNITY COLLEGE DISTRICT
HUMAN RESOURCES DEPARTMENT

SUPERVISOR'S REPORT OF EMPLOYEE INCIDENT OR INJURY

(Any employee receiving benefits as a result of this section shall, during periods of injury or illness, remain within the State of California unless the governing board authorizes travel outside the state. *Education Code §87787 & 88192)*

Please NOTE: Failure to complete form in its entirety may result in a DELAY OF BENEFITS!

TO BE COMPLETED BY EMPLOYEE or MANAGER:

☐ **INCIDENT** (no medical attention required)
☐ **FIRST AID** (per OSHA guidelines)
☐ **INJURY** (reportable to Keenan & Associates)

LOCATION:
☐ Kentfield Campus ☐ Other ______________
☐ Indian Valley Campus

PERSONAL INFORMATION ***(Please type or print clearly)***

Employee Name: ______________________________ SS#: ____________________
Home Address: ______________________________ DOB: ____________________
______________________________ Age: ____________________
Home Phone: ______________________________ Sex: ☐ Male ☐ Female
Email Address: ______________________________

EMPLOYMENT / OCCUPATIONAL STUDENT INFORMATION ***(Please type or print clearly)***

Job Title: ______________________________ Department:______________ Ext.:______
Work Hours: ______________________________ Hours per Day:________10 mo. Employee ☐
Work Days: ______________________________ Days per Week:_______12 mo. Employee ☐
Date of Hire: __________________Wages: $_________ per __________ Time employee started work on day of injury: ____________ ☐ AM ☐ PM
☐ Student Worker ☐Medical Service Provider-Professional Training
Does employee have additional employment outside the MCCD? ☐ Yes ☐ No
If yes, please list the name of the other employer: ______________________________

THIS SECTION AND PAGE 2 - TO BE COMPLETED BY MANAGER:

INCIDENT/INJURY INFORMATION ***(Please type or print clearly)***

Accident Date: ____________________ Injury Reported to: ______________________________
Accident Location: ____________________ Date Reported: ______________________________
____________________ Time Reported: ______________________________

Describe the specific activity employee was performing and how the incident/injury occurred:______________
____
____

Describe the injury (nature of injury and specific body part(s) affected):______________________________
____
____

Name(s) of Witness(es):______________________________ Phone: ____________________
______________________________ Phone: ____________________
Was there another individual ☐ involved in or ☐ responsible for the incident/injury? ☐ Yes ☐ No
If yes, enter name here: ______________________________Home phone: ____________________
Did injured employee leave work to seek medical treatment? ☐ Yes ☐ No Date: __________Time:_________

MEDICAL INFORMATION (*Please type or print clearly)*

Medical Facility Visited: ______________________________ Phone: ____________________

Address: ______________________________ City: ____________ Zip: ____________

Doctor's Name: ______________________________

Did doctor release injured worker to return to work? ☐ Yes ☐ No Date: ____________ Time: __________

If no, estimated return to work date: ____________________ Was employee hospitalized? ☐ Yes ☐ No

Is modified or alternative work available in employee's department? ☐ Yes ☐ No

Accident investigation is critical for identifying the accident causes so they may be corrected. Please answer the following as completely as possible.

ACCIDENT INVESTIGATION INFORMATION *(Please type or print clearly)*

Did the accident/injury occur during the employee's regular work assignment? ☐ Yes ☐ No

If no, please explain: ______________________________

Why did this incident happen (what was the cause)? ______________________________

____

Was an employee's unsafe act or disregard for safety rules or improper equipment involved? ☐ Yes ☐ No

Is additional employee training required? ☐ Yes ☐ No Must work practices be reviewed? ☐Yes ☐ No

Has the employee suffered any other injuries, or symptoms of injury, physical and/or mental, reported or unreported, associated with this incident/injury report? ☐ Yes ☐ No

If yes, explain: ______________________________

____

____

____

(Use additional pages for above explanations as necessary)

NOTE: The State of California's "WORKERS' COMPENSATION CLAIM FORM (DWC 1)" MUST be provided to the employee within 24 hours of knowledge of the incident. If the employee completes this form, the supervisor should submit it to the Fiscal Services Benefits Office immediately. If an injured employee needs treatment by a doctor or a medical facility, a "Treatment Referral Form" authorizing such treatment must also be completed for the employee.

Date State WC Claim Form was provided to employee: ____________________ Time: __________ Location: _________

Supervisor's Name (print): ______________________________ Ext. ____________ Campus: ____________________

Supervisor's Signature: ______________________________ Date: ______________________________

The information provided on this form is an accurate description of the accident/injury circumstances.

Injured Employee's Signature: ______________________________ Date: ______________________________

STEPS TO FOLLOW:

1. Supervisor should start the accident/injury investigation immediately.
2. Call Fiscal Services Benefits Office, ext. 8159 to report any serious injury. Manager should also preserve the scene of the accident and take photos, if possible.
3. Complete and sign this form as soon as possible after the accident and fax **immediately**, along with the completed Employee's Claim for Workers' Compensation Benefits Form (DWC-1) to the Fiscal Services Benefits Office at **(415) 883-3261**, and then place the originals in the interoffice mail. Thank you.