

Employee Injury Report

Sonoma County Office of Education

Instructions: This form is to be completed by the employee's department supervisor, and the employee is to be referred to call the RESIG Early Intervention Nurse at 707-836-7457, **immediately upon receiving notification of a job-related injury/illness/exposure.** Completed forms and/or inquiries should be directed to the administrative assistant in Human Resources. Filing of this form is not an admission of liability.

EMPLOYEE'S NAME: _____ Date of Birth: _____

HOME ADDRESS: _____ Home Phone: _____

CITY/STATE/ZIP: _____ Cell Phone: _____ Sex: M F

Department/Program: _____ Occupation/Title: _____

Worksite/Address: _____ Work phone: _____

DATE INJURY/ILLNESS/EXPOSURE OCCURRED: _____ Hour: _____ a.m. p.m.

DATE INJURY/ILLNESS/EXPOSURE REPORTED: _____ Hour: _____ a.m. p.m.

Specific injury/illness/exposure and part of body affected: _____

Specific activity the employee was performing when injury/illness/exposure occurred: _____

How injury/illness/exposure occurred: _____

NAMES OF WITNESSES: _____

REFERRED TO RESIG EARLY INTERVENTION NURSE (707-836-7457): YES DATE: _____ NO REASON: _____

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 no, 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 _____
- (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 performed 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 performed by: _____
If no, explain _____
- (g) Name of SCOE department/region nurse to contact for information regarding exposure _____

Certification: To the best of my knowledge and belief, this information is true and reflects the facts.

SUPERVISOR'S SIGNATURE: _____ DATE: _____

TO BE COMPLETED BY HUMAN RESOURCES' ADMINISTRATIVE ASSISTANT

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 _____