SUPERVISOR'S REPORT OF ILLNESS/INJURY
COUNTY OF SACRAMENTO
WORKER'S COMPENSATION OFFICE

Phone Number 876-5251 **Fax Number 876-5157**

For SSD Use Only: Report # **Job #** **Division:**

PERSONAL INFORMATION: (Please print or type:

Employee Name: _____ SSN: _____
Employee home phone number: _____ Work phone number: _____
Department: _____ Section: _____
Number of hours worked per week: _____ Time Shift Begins: _____ Ends: _____
Normal Days Off: _____
Regular Employee? ☐ Yes ☐ No If no, explain: _____
Was any informal or formal personnel action considered or taken against the employee within the previous twelve months? ☐ Yes ☐ No

INJURY/ILLNESS INFORMATION:

Type of Injury/Illness (Check One) ☐ Incident Report/First Aid Only
☐ Lost Time ☐ Medical Treatment Expected
Date of Illness/Injury: _____ Time: _____ Date Reported: _____
How was Illness/Injury reported? ☐ In person ☐ Phone ☐ Other
If other, Explain: _____
Where did Illness/Injury occur? _____ _____
(address) (city/zip)

Was employee performing usual job duties when injured? ☐ Yes ☐ No
Did employee work after date of injury? ☐ Yes ☐ No
If yes, date returned? _____ If no, anticipated date of return: _____
Is there any reason to believe this may NOT be a valid claim? ☐ Yes ☐ No
Comments: _____
If incident was witnessed, provide the name(s), address, and phone number of witness(s):
Name(s) _____ Address: Street _____
Phone: _____ City, State, Zip _____
If equipment or property was involved, provide the following:
Owner: _____ Address: Street _____
Phone: _____ City, State, Zip _____
Insurance Company: _____ Address: Street _____
Phone _____ City, State, Zip _____

TREATMENT INFORMATION:

☐ Hospital ☐ Ambulance ☐ Doctor
☐ Nurse ☐ Self Administered ☐ Occ Med Clinic
Provided by: ☐ Other, please explain: _____
Name of person providing treatment: _____
Place of treatment: _____

DESCRIBE HOW THEINJURY OCCURRED: (examples: employee walking down the stairs, tripped & fell injuring right knee on the cement; employee lifting a box, felt a sharp pain in lower back)

_____

BODY PART: (check appropriate box(s) and on the line provided specify the location by indicating LE for Left, RT for Right, BO for Both, FR for Front, and BA for Back)

☐ Head/Skull	☐ Arm _____	☐ Leg _____	☐ Heart	☐ Back, upper	
☐ Nose	☐ Elbow _____	☐ Hip _____	☐ Chest	☐ Back, mid	
☐ Ear _____	☐ Ankle _____	☐ Foot _____	☐ Lung	☐ Back, lower	
☐ Tooth	☐ Finger _____	☐ Knee _____	☐ Abdomen	☐ Neck	
☐ Mouth	☐ Wrist _____	☐ Toe _____	☐ Psyche	☐ Eye _____	
☐ Shoulder _____	☐ Hand _____				
☐ Other					

NATURE OF INJURY: (check appropriate box(s)

☐ Irritation/Inflammation	☐ Emotional Stress	☐ Trauma/Contusion
☐ Sprain/Strain	☐ Heart	☐ Puncture/Laceration
☐ Repetitive Motion	☐ Bite	☐ Abrasion
☐ Fracture	☐ Exposure (to what?)	
☐ Other		

CAUSE OF INJURY/ILLNESS (check appropriate box)

☐ Design of workstation/building	☐ Uneven or slippery surface
☐ Rules/procedures not followed or inadequate	☐ Horseplay
☐ Incorrect body position in relation to work	☐ Exposure (chemical, noise, etc.)
☐ Incorrect tools or mechanical aids used	☐ Vehicle operation
☐ Equipment operated incorrectly	☐ Congested area (storage)
☐ Environmental factors (weather/lighting)	☐ Animal or insect
☐ Action of fellow employee/member of public	☐ Conflict with supervisor
☐ Protective devices or guards	☐ Inattention or distraction
☐ Other (please explain)	

SOURCE OF INJURY: (check appropriate box(s)

☐ Structure	☐ Equipment/tools	☐ Materials
☐ Objects	☐ Environment	☐ Person
☐ Other (please explain)		

PREVENTATIVE MEASURES: (check one or more actions)

☐ Provide more complete job instruction	☐ Update or revise procedures
☐ Enforce work rule	☐ Provide safe equipment
☐ Provide proper tools/equipment	☐ Reinforce employee training
☐ Provide personal protective equipment	☐ Modify workstation or building
☐ Contract third party to effect correction	
☐ Other (please explain)	

Prepared by _____ _____

(Print Supervisor's Name) (Supervisor's Signature)

Phone: _____ **Date**: _____

Please forward <u>this completed form along with your department's 5020 form</u>, within 24 hours after incident to
Workers' Compensation Office
PO BOX 276130
Sacramento, CA 95827
Mail Code 58-600