



# COUNTY OF SONOMA



## Supervisor's Report of Occupational Injury / Illness / Exposure

This report *must be completed by the Supervisor\** and sent to Risk Management within 24 hours of knowledge of the injury. Send copy to Safety Coordinator and follow department procedures.

|                             |   |  |   |  |   |                       |
|-----------------------------|---|--|---|--|---|-----------------------|
| <b>Employee Information</b> | 1. Name of Injured (Last, First)  |  | 2. Employee ID #  |  | 3. Job Title  |                       |
|                             | 4. Department   |  | 5. Division   |  | 6. Work Location  |                       |
|                             | 7. Work Phone   |  | 8. Home Phone   |  |   |                       |
| <b>Employee Information</b> | 9. Employment Type - Paid   |  | 10. Unpaid Worker - Check applicable box and complete sections 11 & 12  |  |   |                       |
|                             | <input type="checkbox"/> Full Time<br><input type="checkbox"/> Part Time <b>SKIP TO #13</b><br><input type="checkbox"/> Extra Help<br><input type="checkbox"/> Seasonal   |  | <input type="checkbox"/> Volunteer<br><input type="checkbox"/> Intern<br><input type="checkbox"/> Work Release / SAC<br><input type="checkbox"/> General Assistance |  | 11. Home Address  |                       |
|                             |   |  |   |  | 12. Last 4 digits social security   |                       |
| <b>Incident Information</b> | 13. Date of Injury  |  | 14. Time of Injury  |  | 15. Time Shift Began  |                       |
|                             |   |  |   |  | 16. Did injury occur during overtime?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |                       |
|                             | 17. Location of injury. (Building and specific area, or address for non-county locations)   |  |   |  | 18. Did injury occur on County property?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                      |                       |
|                             | 19. Body part(s) injured or affected by illness or exposure (list all affected).  |  |   |  | 20. Was repetitive motion activity involved?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |                       |
|                             | 21. What type of injury/illness/exposure? (e.g. cut, sprain, bruise, pain, scrape, etc.)  |  |   |  | 22. Were other persons injured?<br><input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, see #29, & #30                     |                       |
|                             | 23. What specific activity was the employee doing when the injury occurred? (e.g. loading boxes into truck)   |  |   |  |   |                       |
|                             | 24. Describe in detail how the injury occurred. Provide the sequence of events. Include what employee was doing prior to the injury.  |  |   |  |   |                       |
|                             | 25. Equipment or material employee was using when injury occurred (e.g. keyboard, ladder, forklift, etc.)   |  |   |  | 26. County Vehicle?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |                       |
|                             | 27. Date of employer's knowledge of injury  |  |   | 28. Did Employee ASK for a Workers' Compensation Claim Form?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |                       |
|                             | 29. Name(s) of witnesses or other persons injured.  |  |   | 30. Phone number(s) of witnesses or others injured   |   |                       |
| <b>Medical Information</b>  | 31. Medical services provided by: (check all that apply)  |  |   | 32. Name of medical provider (if other than Kaiser Occupational Health)  |   |                       |
|                             | <input type="checkbox"/> No First Aid or Medical Services- Injury Report Only<br><input type="checkbox"/> First Aid at Work Location<br><input type="checkbox"/> Kaiser Occupational Health<br><input type="checkbox"/> Personal Medical Provider<br><input type="checkbox"/> Emergency Room<br><input type="checkbox"/> Inpatient Hospitalization<br><input type="checkbox"/> Transported by Ambulance |  |   | 33. Address and phone of medical provider listed in # 32, if known   |   |                       |
|                             | } -- Complete #32 & #33   |  |   | 34. Date employee last worked (if time was lost beyond date of injury)   |   |                       |
|                             |   |  |   |  |   |                       |
| <b>Supervisor</b>           | Supervisor's Name (print name)  |  |   | Supervisor's Email   |   | Supervisor's Phone    |
|                             | Temporary Supervisor (completing on behalf of regular supervisor)   |  |   | Temporary Supervisor's Phone   |   | Date Report Completed |

\* See Instructions for Completion of the Supervisor's Report of Occupational Injury / Illness / Exposure