Citrus Community College District

Supervisor's Report of Employee Injury

Supervisor: Submit this form within 24 hours to the Office of Human Resources. *Only you or your designee shall complete this form on behalf of the injured employee.*

Today's Date: _____ **Name of Injured:** _____

Date of Birth: _____ **Address & Telephone #:** _____

Job Title: _____ **Date Hired:** _____

Employee's Normal Work Schedule: _____

Date of Accident: _____ **Hour:** _____ am/pm

Location of Accident: (Please Be Specific): _____
_____
_____

Describe How the Accident Occurred (Facts *Only*. Exclude opinions or assumptions as to cause):
_____
_____
_____

Witness(es) If any. **Address** and **Phone**:

What is the observable nature of the Injury?
(Please describe): _____
_____

On the day of the injury, did the employee, because of the injury:

Leave Work? _____, If yes, Date: _____ Time: _____ am/pm

Return to work? ____, If yes, Date: _____ Time: _____ am/pm

Corrective Action: What changes in the worksite or work procedures could be taken to prevent this accident from occurring again? _____
_____

Supervisor's Signature: _____ Date: _____

Distribution: Original to Human Resources | Copy to Environmental Health and Safety Supervisor