Long Beach Unified School District
Risk Management Branch
EMPLOYEE'S SITE ACCIDENT/INCIDENT REPORT

Report an accident/incident within 24 hours, no matter how trivial. Complete and give two copies to your site manager. A copy will be returned to you.

Name of Employee (First) (MI) (Last)	**Social Security Number**	**Date of Birth**

Home Address (Number and Street) (City) (ZIP)	**Telephone (home)**	**(work)**

Male ☐ **Female** ☐ **Other** ☐	**Occupation (regular title, not specific activity at time of injury)**	**Date of Hire**

Department in which regularly employed	**Pay Location Code**

Date of injury or illness	**Time of Day** _____**A.M.**_____**P.M.**	**Were you unable to work on any day after injury?** Yes ☐ date last worked_____ No lost time ☐

Have you returned to work?
YES ☐ **, date returned** _____ **NO, still off work** ☐

Nature of injury or illness and part of body affected
(DO NOT WAIT FOR DOCTOR'S REPORT)

Where did the accident occur? (address, city and county, name of worksite)	**On employer's premises?** **Yes** ☐ **No** ☐

What were you doing when injured? (Be specific, identify tools, equipment or material you were using and area where you were working)

Object or substance that directly injured you (e.g., the machine you struck against or which struck against you; the chemical that irritated your skin; the thing you were lifting or pulling, etc.)

How did the accident or exposure occur? (Describe fully the events that resulted in injury or occupational disease. Tell what happened and how it happened. Use separate sheet if necessary)

Was there a witness? **Yes** ☐ **No** ☐	**Name of Witness**	**Was another person responsible?** **Yes** ☐ **No** ☐	**Name**

If seen by a doctor, give name and address of physician	**If hospitalized, name and address of hospital**

EMPLOYEE: The information given is correct to the best of my recollection

_____
Signature of Employee **Date**

MANAGER: This report was submitted to me on _____
Date

_____
Signature of Manager **Date**

The Workers' Compensation Claim Form (DWC 1) was provided to the employee on _____
Date

Original-Risk Management ***Copy-Return to Employee*** ***Rev.8/2020***