REFERENCES: 8CCR-3203
EH&S RR-03

FILE or CASE NO.	

(From Police Supplementary Record)

LOS ANGELES COMMUNITY COLLEGE DISTRICT
SUPERVISORS REPORT OF EMPLOYEE INJURY OR ILLNESS

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NOTE: *This form should be completed* and *sent to the District Workers' Compensation Office within five (5) days of the reported injury.*

SECTION I: ADMINISTRATIVE

COLLEGE.		DEPT./DIV.	
EMPLOYEE NAME		POSITION CLASSIFICATION	
DATE AND TIME OF INJURY OR ILLNESS		DATE AND TIME SUPERVISOR KNEW OF EMPLOYEE INJURY OR ILLNESS	
INCIDENT LOCATION		NATURE OF INJURY	

SECTION II: EMERGENCY TREATMENT

TYPE OF TREATMENT RENDERED (Ö)	NAME(S) OF FIRST AID RESPONDERS, MEDICAL PROFESSIONALS OR EMERGENCY TREATMENT PROVIDERS	BLOODBORNE PATHOGENS EXPOSURE INCIDENT? ☐ NO ☐ YES *IF YES, SPECIFY ROUTE OF ENTRY BELOW*	NAME(S) OF WITNESSES TO THE OCCUPATIONAL INJURY OR ILLNESS
☐ FIRST AID (SELF ADMIN)		☐ INGESTION	
☐ FIRST AID by EMPLOYEES		☐ INHALATION	
☐ FIRST AID by PHYSICIAN or NURSE		☐ PARENTERAL	
☐ EMERGENCY TREATMENT		☐ ABSORPTION	

SECTION III: DESCRIPTION OF HOW THE EMPLOYEE WAS INJURED

LOS ANGELES COMMUNITY COLLEGE DISTRICT
SUPERVISOR'S REPORT OF EMPLOYEE INJURY OR ILLNESS

SECTION IV: FACULTY INSPECTION OBSERVATIONS

SECTION V-. EMPLOYEE SAFE WORK PRACTICES

SECTION VI:- ACTIONS TAKEN TO PREVENT RECURRENCE

☐ EMPLOYEE TRAINING ☐ PROCEDURE REVISION ☐ MAINTENANCE SERVICE REQUEST ☐ SIGNS, TAGS, LABELS

SUPERVISOR *(Print Name)*		SUPERVISOR (*Signature/Date*)	
ADMINISTRATOR *(Print Name)*		ADMINISTRATOR *(Signature/Date)*	

REFERENCES: 8CCR 3203
EH&S RR-03