REPORT OF INDUSTRIAL INJURY
MCCCD Employee & Supervisor

Employee's Information

Employee Name: Last, First, M.I.: _____ Employee ID# _____

Job Title: _____ Campus:

Department Name: _____ Department I.D.# _____

Employee's Phone #: _____ Supervisor Name: _____

Work Schedule:
Shift Begins at _____ ☐ a.m. ☐ p.m. Shift Ends at: _____ ☐ a.m. ☐ p.m.

Select days in work schedule:
☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Injury/Accident

Date of Accident: _____ Time: _____ ☐ a.m. ☐ p.m.

Date Accident was Reported: _____ Time: _____ ☐ a.m. ☐ p.m.

Medical Attention: If, yes where:

Address where the accident occurred: _____
Number & Street City State Zip Code

Location where the accident occurred: Building/Department: _____

How did the accident occur? _____

What object and/or substance harmed the employee: _____

Part of body affected: _____ ☐ Right ☐ Left ☐ Upper ☐ Lower ☐ Laceration ☐ Scrape ☐ Bruising
☐ Broken bone(s) ☐ No Visible signs of injury but has pain ☐ Other: _____

Part of body affected: _____ ☐ Right ☐ Left ☐ Upper ☐ Lower ☐ Laceration ☐ Scrape ☐ Bruising
☐ Broken bone(s) ☐ No Visible signs of injury but has pain ☐ Other: _____

What was the employee doing just before the accident occurred: _________

Description of job duties being performed: _____

Other: _____

Was any other person(s) affected by this accident:

If, yes please complete the following: Name(s), employee ID, and Contact phone number: _____

Please attach a copy of their Industrial Injury Report.

Were there any witnesses to the accident:

If, yes please complete the following: Name(s), employee ID, and Contact phone number: _____

If validity of claim is doubted, state reason: _____

Was College Safety contacted:

Was a College Safety report completed:

Employee's Name: _____
Employee's Phone Number: _____

Employee's Signature*: ______________________
Date: _____________________

Supervisor's Name: _____
Supervisor's Phone Number: _____

Supervisor's Signature*: _____________________
Date: _____________________

Person Completing this Form:
Name: _____

Signature: _________________ Date: _______

***Please do not hold up report due to signatures. Process this document within 24 hours of the accident with District Risk Management and your College Workers' Compensation Representative (Public Safety and/or the Human Resources Department).**

Original – District Risk Management, Copy – Supervisor, Copy – Public Safety, Copy – College HR

Date Received By College: _________________ Date Received By Risk Management: _________