Peralta.edu
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Oakland, CA 94606
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EMPLOYEE STATEMENT OF OCCUPATIONAL INJURY OR ILLNESS

EMPLOYEE PERSONAL INFORMATION

EMPLOYEE NAME: _____ EMPLOYMENT SITE: _____

HOME ADDRESS: _____ PHONE NUMBER: _____

JOB TITLE _____ DATE OF BIRTH: _____

SOCIAL SECURITY #: _____

HOURS PER DAY _____ WORK DAYS ☐ SUN ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ SAT

PLEASE ANSWER ALL THE QUESTIONS BELOW AND SUBMIT TO YOUR SUPERVISOR.

1. DATE OF INJURY/ILLNESS: _____ DATE REPORTED: _____
2. TIME YOU BEGAN WORK: _____ ☐ AM ☐ PM TIME OF INJURY: _____ ☐ AM ☐ PM
3. EXACT LOCATION WHERE INJURY/ILLNESS OCCURRED:

4. DEPARTMENT/SITE WHERE EVENT OCCURRED:

5. PLEASE STATE SPECIFIC PART OF BODY AFFECTED AND TYPE OF INJURY:

6. PLEASE STATE EQUIPMENT, MATERIALS AND/OR CHEMICALS BEING USED WHEN INJURY OCCURRED

7. EXPLAIN THE CIRCUMSTANCES AND/OR ACTIVITY RELATED SPECIFICALLY TO THE INJURY/ILLNESS. DESCRIBE THE SEQUENCE OF EVENTS THAT LED TO THE INCIDENT THAT DIRECTLY AFFECTED THE INJURY/ILLNESS (USE BACK OF FORM IF NECESSARY.)

8. WAS ANYONE ELSE INJURED? ☐ NO ☐ YES: (IDENTIFY) _____
9. WHO DID YOU NOTIFY REGARDING THIS ACCIDENT/ILLNESS: _____
10. PLEASE NAME ANY WITNESSES: _____

SIGNATURE _____ DATE _____