

Santa Barbara County Schools - Self Insured Program For Employees (SIPE)  
**Employee's and Supervisor's Industrial Incident Report - Page 1 of 2**

(If handwritten, please print clearly. Forward page 2 to employee's supervisor)

District  Today's Date

**Employee's Report**

(to be completed by employee, employee's designee or by district claims representative)

Employee Name  Social Security Number  Date of Birth

Home Address  Home Phone

Sex  Male  Female Job Title  Date of Hire

Usual Work Hours hrs/day  days/wk  Total hrs/wk

Employment Status  Regular Full-Time  Part-Time  Temporary  Seasonal

Gross Wages/Salary \$  per

Other payments not reported as wage/salary (e.g. tips, meals, lodging, overtime, bonuses)  Yes \$  per

Worksite/Program  Employee's Supervisor

Date of Illness/Injury  Time of Day   Time Started Work Shift

Description of Injury or Exposure (sprain, fracture, skin rash, etc.)

Where did incident occur? (include address if other than primary worksite)

On Employer's premises?  Yes  No

What were you doing at time of incident?

How did the incident occur? (please describe fully the events that resulted in injury or exposure; specify object or exposure that directly produced injury or illness)

Was another person responsible?  Yes  No Name

Name(s) of witnesses, if any

If seen by a doctor, give name, address, phone and fax number of doctor

If hospitalized, give name, address, phone and fax number of hospital

Have you missed a shift or day of work due to this condition?  Yes  No

Have you received care beyond first aid for this conditions?  Yes  No

Have you been provided with a claim form?  Yes  No

Have you been provided a "Facts for Injured Workers" brochure since this incident?  Yes  No

Completed by  Relationship to Employee  Date

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(If handwritten, please print clearly)

Employee Name  District   
Date of Injury/Illness  Job Title   
Brief Description of injury or exposure (sprain, fracture, skin rash, etc.)

**Supervisor's Review**

(Please investigate casual factors to prevent reoccurrence)

What was the employee doing when injured or exposed?   
Object or substance that directly injured or exposed employee?   
Was Employee able to work after injury or exposure?  Yes  No Time and Date last worked   
Has Employee returned to work?  Yes  No Date Returned   
Have you obtained information regarding the injury or exposure from witnesses?  Yes  No  
Was there a safety hazard involved in this incident?  Yes  No  
Has the safety hazard or unsafe condition been corrected?  Yes  No  
If Yes, explain action taken:   
How could injury or exposure have been prevented?   
What action have you taken to prevent reoccurrence?

Supervisor's Name  Phone Number   
Supervisor's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Safety Commitee Review**

Factors causing or contributing to this injury or exposure? \_\_\_\_\_

This Injury or exposure was  Preventable  Non-Preventable

Rationale/Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Safety Director \_\_\_\_\_ Date \_\_\_\_\_

District Safety Committee Review \_\_\_\_\_ Date \_\_\_\_\_