REPORT of INCIDENT

[Form RM-03] Rev. 7/2010

This **report** is for a(n):
- ☐ ACCIDENT
- ☐ INJURY
- ☐ ILLNESS
- ☐ Report Only

[check all that apply]

The **affected party** is a(n):
- ☐ STUDENT
- ☑ EMPLOYEE
- ☐ VOLUNTEER
- ☐ VISITOR
- ☐ Other:

LOCATION CODE:

INCIDENT NUMBER:

CLAIM NUMBER (if appl):

OFFICE USE ONLY

AFFECTED PARTY

FULL **NAME:**	**JOB TITLE** (if applicable):
HOME **ADDRESS:**	**WORK** PHONE:
CITY, STATE and **ZIP:**	**HOME** PHONE:

INCIDENT INFORMATION

INCIDENT **ADDRESS:**	**DATE** of INCIDENT:
CITY, STATE and **ZIP:**	**TIME** of: INCIDENT **AM / PM**

DESCRIBE the ACTIVITY OCCURING **JUST PRIOR to the INCIDENT**:

☐ **[#1] CONTINUED on BACK**

DESCRIBE **HOW the INCIDENT OCCURRED**:

☐ **[#2] CONTINUED on BACK**

OBJECT, EQUIPMENT or CHEMICAL THAT **DIRECTLY CAUSED HARM**:

MANAGER or SUPERVISOR IN CHARGE at TIME of INCIDENT:	CONTACT **PHONE**:
WITNESS NAME (if applicable):	WITNESS **PHONE:**
WITNESS NAME (if applicable):	WITNESS **PHONE:**

INJURY INFORMATION

DESCRIBE any **INJURY or ILLNESS (DIAGNOSIS)**:

SOUGHT **TREATMENT?** **Yes / No**	TREATED in an **EMERGENCY ROOM?** **Yes / No**	**HOSPITALIZED OVERNIGHT** as an INPATIENT? **Yes / No**	DATE of **DEATH** (if applicable):

HOSPITAL or **CLINIC NAME** and **CITY**:	PHYSICIAN: **NAME:**
FIRST AID GIVEN at the **SCENE**:	PHYSICIAN **PHONE**:

TIME

SCHEDULED WORK HOURS **From:** **AM / PM** **To:** **AM / PM**	**LOST TIME** from **WORK?** **Yes / No**	**DATES MISSED** **From:** **To:**

SIGNING THIS FORM DOES NOT NECESSARILY CONSTITUTE ACCEPTANCE OF A CLAIM.

ATTENTION: This form contains information relating to employee health and must be used in a manner that protects the confidentiality employees to the fullest extent possible while the information is being used for occupational safety and health purposes. See e.g. 8 C.C.R. § 14300.29(b)(6)-(10).

Within 7 days of knowledge that a "recordable" injury or illness has occurred, supervisors must ensure that this form, or the Cal/OSHA Form 301, are completed.

FAX or E-MAIL a COPY of this completed form to **RISK MANAGEMENT** at: **(510) 644-8881**

FOR INFORMATION THAT WILL NOT FIT ON THIS FORM, PLEASE ATTACH ADDITIONAL SHEETS.

NAME and TITLE of REPORTING PARTY:	SIGNATURE:	DATE: