



Berkeley Unified School District

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 OCCURRING JUST PRIOR to the INCIDENT:	
	<input type="checkbox"/> [#1] CONTINUED on BACK	
	DESCRIBE HOW the INCIDENT OCCURRED:	
	<input type="checkbox"/> [#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: To: AM / PM AM / PM	LOST TIME from WORK? Yes / No	DATES MISSED	From: To:
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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:
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