Long Beach Unified School District
Risk Management Branch
EMPLOYEE'S SITE ACCIDENT/INCIDENT REPORT

Report an accident/incident within 24 hours, no matter how trivial. Complete and give two copies to your site manager. A copy will be returned to you.

Name of Employee (First) (MI) (Last)	Social Security Number	Date of Birth
Home Address (Number and Street) (City) (ZIP)	Telephone (home) (work)	

Sex Female____ Male ____	Occupation (regular title, not specific activity at time of injury)	Date of Hire
Department in which regularly employed		Pay Location Code

Date of injury or illness _____ /_____ / _____ Mo. Day Year	Time of Day _____A.M. _____P.M.	Were you unable to work on any day after injury? Yes____, date last worked_____ No lost time____

Have you returned to work?
YES_____, date returned_____ NO, still off work_____

Nature of injury or illness and part of body affected
(DO NOT WAIT FOR DOCTOR'S REPORT)

Where did the accident occur? (address, city and county, name of worksite)	On employer's premises? Yes____ No____

What were you doing when injured? (Be specific, identify tools, equipment or material you were using and area where you were working)

_____

_____

_____

Object or substance that directly injured you (e.g., the machine you struck against or which struck against you; the chemical that irritated your skin; the thing you were lifting or pulling, etc.)

_____

_____

_____

How did the accident or exposure occur? (Describe fully the events that resulted in injury or occupational disease. Tell what happened and how it happened. Use separate sheet if necessary)

_____

_____

Was there a witness? Yes____ No____	Name of Witness	Was another person responsible? Yes____ No____	Name
If seen by a doctor, give name and address of physician		If hospitalized, name and address of hospital	

EMPLOYEE: The information given is correct to the best of my recollection

_____
Signature of Employee Date

MANAGER: This report was submitted to me on _____
Date

_____
Signature of Manager Date

The Workers' Compensation Claim Form (DWC 1) was provided to the employee on _____
Date