YUBA COUNTY OFFICE OF EDUCATION
935 14TH STREET, MARYSVILLE, CA 95901

EMPLOYEE INJURY / INCIDENT REPORT

EMPLOYEE NAME: ___________________________ WORK LOCATION: ___________________________

TITLE: ___________________________ SUPERVISOR’S NAME: ___________________________

DATE OF INCIDENT: ______________ TIME: ______________ LOCATION: ___________________________

DATE REPORTED: ______________ PHONE NUMBER: ___________________________

DO YOU REQUIRE MEDICAL ATTENTION NOW?  YES  NO

(Checking “NO” means you do not need IMMEDIATE medical attention, but you may wish for future medical care.)

If medical attention is needed, contact the Company Nurse Injury Hotline immediately at 1-877-518-6709, use code TCS16

If medical treatment is not needed at this time, complete this form and leave it with the site secretary or supervisor who will forward it to the Human Resources Department. If medical attention is not needed now for this incident, but is necessary at a later date you understand that you MUST contact the County Office Human Resources Department immediately @ 749-4900 PRIOR TO seeking or obtaining medical treatment. If you feel you need medical attention after hours or on the weekends, our designated clinic is Adventist-Rideout Occupational Health, 1531 Plumas Court, Suite B in Yuba City or the Emergency Room at Rideout Memorial Hospital, 726 4th Street, Marysville.

IMPORTANT: Failure to report occupational injuries in a timely manner and/or failure to comply with the Counties’ policies for medical treatment of occupational injuries could result in a delay of any possible workers’ compensation benefits while the County and the insurance carrier investigate your claim.

HOW DID INCIDENT HAPPEN? ____________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

DESCRIPT THE INCIDENT AND PART OF BODY AFFECTED: ______________________________________

____________________________________________________________________________________

____________________________________________________________________________________

ANY WITNESSES?  YES  NO IF YES, GIVE NAME(S): ___________________________

HAVE YOU HURT THIS PART OF YOUR BODY BEFORE?  YES  NO IF YES, EXPLAIN: ______________

____________________________________________________________________________________

____________________________________________________________________________________

WERE YOU EXPOSED TO ANY BLOODBORNE PATHOGENS OR POTENTIALLY INFECTIOUS MATERIALS?

 YES  NO IF YES, YOU MUST NOTIFY Company Nurse IMMEDIATELY at 1-877-518-6709, use code TCS16.

FOLLOW-UP COMMENTS: To be filled out by staff, not injured employee.

____________________________________________________________________________________

If additional space is needed, please use back of page.

Employee’s Signature ___________________________ Date ______________

Supervisor’s Signature ___________________________ Date ______________

07/10/2019 jaa