



County of Sonoma

Instructions for Completion of the Supervisor's Report of Occupational Injury/Illness/Exposure



The Supervisor's Report of Occupational Injury/Illness/Exposure (Supervisor's Report) is to be completed by the injured employee's immediate supervisor **within 24 hours** and forwarded to Risk Management by email to workcomp@sonoma-county.org or facsimile at **(Fax number) 526-0101**.

A copy should also be immediately provided to the Department Safety Coordinator.

The following are step-by-step instructions to complete the Supervisor's Report. For the purposes of these instructions, the term "injury" also means an illness or exposure. All instructions refer to a County employee, except #10, #11 and #12, which apply to an unpaid worker. Complete all applicable sections.

EMPLOYMENT INFORMATION

1. **Name of injured:** Enter the injured person's last name, followed by the first name.
2. **Employee ID #:** If the injured is a County employee, enter his or her ID number.
3. **Job title:** Enter the job title at the time of injury.
4. **Department:** Enter the employee's Department.
5. **Division & Section:** Enter the employee's Division # and Section #.
6. **Work location:** Enter the location where the employee usually reports to work.
7. **Work phone:** Enter the employee's work telephone number.
8. **Home phone:** Enter the home phone or personal cell phone number of injured person.
9. **Employment type-paid:** If the injured person is a County employee check the box for the applicable type of employment. Then proceed to section 13.
10. **Unpaid Worker:** If the injured person is an unpaid worker (not a County employee), check the box indicating the type of unpaid worker, and complete sections 11 and 12.
11. **Home address:** Enter the home address of the unpaid worker
12. **Social Security #:** Enter the social security number of the unpaid worker.

INCIDENT INFORMATION

13. Date of injury/illness/exposure:

Injury: If the injury or exposure was caused by an accident, happened as the direct result of a specific action, or began suddenly due to an event or condition, enter date (month, day, and year) the injury or exposure occurred as the "Date of Injury". If date is unknown, follow the guidance below under 'Cumulative/Ergonomic/Repetitive Motion Injury.'

Illness: If this is an illness, enter the date the condition was diagnosed as an occupational illness by a medical professional. If this is an alleged or undiagnosed illness enter the date the employee was sent to the Occupational Medicine Provider for an evaluation.

13. Date of injury/illness/exposure: (continued)

Re-injury: If this is believed to be a reoccurrence of a previous injury which healed and resolved, clearly note this is believed to be a "re-injury" in section #24 below, and enter the date (month, day, and year) the body part was re-injured as the "Date of Injury".

Cumulative/Ergonomic/Repetitive Motion Injury: An ergonomic, repetitive motion or cumulative trauma injury is caused by repeated actions or activities over a period of time. It is usually not possible to determine the exact date an ergonomic injury began. Therefore, the method to establish the "Date of Injury" for an ergonomic injury for reporting and recordkeeping purposes is to determine which of the following occurred first:

- The date the injury was first reported, or
- The date of diagnosis by licensed medical professional, or
- If the employee is currently off work, the first day of lost time due to this injury.

These events could all happen on the same day, but, in most circumstances, one will occur before the other(s). Confirm which of these occurred first, and enter the date that event as the "Date of Injury". Please do not enter, "unknown", "continuous", "on-going", or dates from the past.

- 14. Time of injury/illness:** Enter the time of day (a.m./p.m.) the injury occurred. If this was an ergonomic (repetitive motion injury) as defined in #13, leave this section blank.
- 15. Time shift began:** Enter the time work began on the date of injury. If this was an ergonomic (repetitive motion injury) as defined in #13, leave this section blank.
- 16. Did injury occur during overtime?** Check yes or no to indicate whether injury occurred while working overtime.
- 17. Location of injury:** Provide the name of the building and location, AND the zip code of the location (e.g. loading dock, jail cell, cubicle, etc.) where the injury occurred. For injuries that occurred outside of County locations, provide the address.
- 18. Did injury occur on County property?** Check yes or no. If no, include address in section box #17.
- 19. Body part injured or affected by illness or exposure (list all):** List all body parts injured, or affected by illness or exposure (e.g. wrist, low back, knee).
- 20. Was repetitive motion activity involved?** Is this an Ergonomic, Repetitive Motion, Cumulative Trauma injury caused by repetition or exposures over a period of time? Check yes or no. If it is unclear at the time the Supervisor's Report is completed, enter "unknown".
- 21. What type of injury/illness/exposure?** Describe the injury, and/or symptoms being reported by the employee. (pain, cut, bruise, rash, scrape, sprain, soreness, etc.)
- 22. Were other persons injured?** Check yes or no. If yes, make sure box #28 and #29 are also complete.
- 23. What specific activity was the employee doing when the injury occurred?** Describe the activity, job or task being performed. Examples: Loading boxes; restraining a suspect; data entry; climbing a ladder; driving.

24. **Describe in detail how the injury occurred:** Provide a full description of the events and circumstances related to the injury, including the events leading up to the injury and the medical response if applicable.
25. **Equipment or material employee was using when injury occurred:** Describe the equipment, materials, or tool being used when the injury occurred.
26. **County Vehicle?** Check yes or no.
27. **Date of employer's knowledge of injury:** Enter the month, day and year a manager, supervisor or administrative staff (i.e., Director, Officer, Analyst, etc.), first became aware the employee suffered, or reports a work related injury.
28. **Did the employee ask for a workers' compensation claim form?** Check yes or no. If yes, Risk Management will provide the employee or worker with a claim form.
29. **Names of witnesses to the injury or others persons injured:** If the injury is witnessed by others, list the name of the witness. If other employees or persons are also injured at the same time, list the name(s).
30. **Phone number of witnesses or others injured:** Provide the telephone numbers for any witnesses and/or other persons injured.

MEDICAL INFORMATION

31. **Medical Services provided by:** Check each applicable box.
32. **Name and phone of medical provider:** If the injured person received or plans to seek medical services from a provider other than KAISER, enter the name of the provider, if known.
33. **Address of medical provider listed in #32, if known:** If the person received or plans to seek medical services from a provider (not KAISER), enter the provider's address and phone number, if known.
34. **Date employee last worked:** If the injury resulted in time lost beyond the date of injury, provide the day, month and year of the last day worked.

SUPERVISOR

Supervisor's Name: The injured employee or worker's regular assigned supervisor must complete this report if available. The supervisor enters his or her name, e-mail address, telephone number, and date the report is completed in the appropriate sections.

Temporary supervisor: If the employee or worker's regular assigned supervisor is not available, (due to vacation, training, sick or other leave, etc.) the temporary supervisor on the date the report is completed, will print his or her name and phone number and the date the report is completed in the sections provided. Also, enter the name, e-mail address, and phone number of the regular supervisor in appropriate sections.

Under NO circumstance shall the Supervisor's Report be completed by the injured employee.

For questions regarding completion of the Supervisor's Report contact:
Risk Management Unit at (707) 565-2331