COUNTY OF SONOMA

Supervisor's Report of Occupational Injury / Illness / Exposure

This report must be completed by the Supervisor and sent to Risk Management within* **24 hours** *of knowledge of the injury. Send copy to Safety Coordinator and follow department procedures.*

Employee Information

1. Name of Injured (Last, First)	2. Employee ID #	3. Job Title

4. Department	5. Division & Section	6. Work Location	7. Work Phone	8. Home Phone

9. Employment Type - Paid	10. Unpaid Worker - Check applicable box and complete sections 11 & 12	11. Home Address	12. Last 4 digits social security
☐ Full Time ☐ Part Time **SKIP TO #13** ☐ Extra Help ☐ Seasonal	☐ Volunteer ☐ Intern ☐ Work Release / SAC ☐ General Assistance		

Incident Information

13. Date of Injury	14. Time of Injury	15. Time Shift Began	16. Did Injury occur during overtime?
			☐ Yes ☐ No

17. Location of injury w/ Zip Code. (Building/specific area, address if non-county location)	18. Did injury occur on County property?
	☐ Yes ☐ No
19. Body part(s) injured or affected by illness or exposure (list all affected).	**20. Was repetitive motion activity involved?**
	☐ Yes ☐ No ☐ Unknown
21. What type of injury/illness/exposure? (e.g. cut, sprain, bruise, pain, scrape, etc.)	**22. Were other persons injured?**
	☐ Yes ☐ No If yes, see #29, & #30

23. What specific activity was the employee doing when the injury occurred? (e.g. loading boxes into truck)

24. Describe in detail how the injury occurred. Provide the sequence of events. Include what employee was doing prior to the injury.

25. Equipment or material employee was using when injury occurred (e.g. keyboard, ladder, forklift, etc.)	26. County Vehicle?
	☐ Yes ☐ No

27. Date of employer's knowledge of injury	28. Did Employee ASK for a Workers' Compensation Claim Form?
	☐ Yes ☐ No
29. Names(s) of witnesses or other persons injured.	**30. Phone number(s) of witnesses or others injured**

Medical Information

31. Medical services provided by: (check all that apply)	32. Name of medical provider (if other than Kaiser Occupational Health)
☐ No First Aid or Medical Services- Injury Report Only ☐ First Aid at Work Location ☐ Kaiser Occupational Health ☐ Personal Medical Provider ☐ Emergency Room ☐ Inpatient Hospitalization (Personal Medical Provider, Emergency Room, Inpatient Hospitalization - - Complete #32 & #33) ☐ Transported by Ambulance	**33. Address and phone of medical provider listed in # 32, if known** **34. Date employee last worked (if time was lost beyond date of injury)**

Supervisor

Supervisor's Name (print name)	Supervisor's Email	Supervisor's Phone
Temporary Supervisor (completing on behalf of regular supervisor)	**Temporary Supervisor's Phone**	**Date Report Completed**

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

 Submit to Risk via email WorkComp@sonoma-county.org or fax (707)526-0101