Bonita Unified School District

Report of Occupational Injury or Illness or Accident

Items #1 thru #23 Employee Statement – *If you need more room, please write on the back of the form.*

1. Name of Employee:			2. Social Security Number:
3. Home Address:			4. Phone (Home/Work):
5. Job Title:			6. Date of Birth: (MM/DD/YYYY)
7. School/Department Assigned:			8. Date of Hire: (MM/DD/YYYY)
9. Job Title:	10. Time of Day: ☐ a.m. ☐ p.m.	11. Start Work: ☐ a.m. ☐ p.m.	12. Sex: ☐ Male ☐ Female
13. Name of Employee:		14a. Start Work: ☐ a.m. ☐ p.m.	14b. Rate of Pay: ☐ a.m. ☐ p.m.
15. Location of Accident? (be specific, school name and location at school)			
16. What were you doing when injured? (be specific, identify tools or equipment involved)			
17. Nature of injury or illness: (identify the part of body affected)			
18. If you have received medical attention, indicate the name of the physician or medical facility:			
19. Have you ever been treated for a similar injury or illness? ☐ NO ☐ YES (If yes, please indicate the date, name, and address of the treating physician or medical facility.			
20. Names of any witnesses to this accident:			
21. Recommendation to prevent accidents of this type:			

Note: Treatment is authorized ONLY by physicians designed by the District/WellComp Medical Provider Network unless the employee has pre-designated a physician.

I declare under penalty of perjury that the foregoing is true and correct.

22. Employee Signature:	23. Date:

Items #24 thru #31 Supervisor Statement – *If you need more room, please write on the back of the form.*

24. Supervisor's description of the accident:		
25. Action taken to assist employee:		
26. Recommendation for corrective action:		
27. Date employee last worked:	28. If the employee has returned to work, give the date:	
29. Supervisor Signature:		30. Date:

Send Form To: Christine Froio, Business Office, 115 W. Allen Avenue, San Dimas, CA 91773

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