Santa Barbara County Schools – Self Insured Program For Employees (SIPE)

Employee's and Supervisor's Industrial Incident Report – Page 1 of 2

(If handwritten, please print clearly. Forward page 2 to employee's supervisor)

District Santa Maria Joint Union High School District Today's Date _____

Employee's Report

(To be completed by employee, employee's designee or by district claims representative)

Employee Name _____ Social Security Number _____ Date of Birth _____

Home Address _____ Home Phone _____

Sex ☐ Male ☐ Female Job Title _____ Date of Hire _____

Usual Work Hours hrs./day _____ days/wk. _____ Total hrs./wk. _____

Employment Status ☐ Regular Full-Time ☐ Part-Time ☐ Temporary ☐ Seasonal

☐ Gross Wages/Salary $ _____ per _____

Other payments not reported as wage/salary (e.g. tips, meals, lodging, overtime, bonuses) ☐ Yes $ _____ per _____

Worksite/Program _____ Employee's Supervisor _____

Date of Illness/Injury _____ Time of Day _____ Time Started Work Shift _____

Description of Injury or Exposure (sprain, fracture, skin rash, etc.) _____

Was another person responsible? ◯ Yes ◯ No Name _____

Name(s) of witnesses, if any _____

If seen by doctor, give name, address, phone, and fax number of doctor _____

If hospitalized, give name, address, phone, and fax number of hospital _____

Have you missed a shift or day of work due to this condition? ◯ Yes ◯ No

Have you received care beyond first aid for this condition ◯ Yes ◯ No

Have you been provided with a claim form? ◯ Yes ◯ No

Have you been provided a "Facts for Injured Workers" brochure since this Incident? ◯ Yes ◯ No

Completed by _____ Relationship to Employee _____ Date _____

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Extracted from SIPE Form 6-588 1 11/00 Revised 4/2020

(Please print clearly – Please use a separate sheet of paper if you need more space for your response)

Employee Name:	**District:** Santa Maria Joint Union High School District
Date of injury/illness:	**Job Title:**
Brief description of injury or exposure (sprain, fracture, skin rash, etc.):	
Supervisor's Review: Investigate causal factors to prevent re-occurrence. What was the employee doing when injured or exposed?	
Object or substance that directly injured or exposed employee:	
Was employee able to work after injury/exposure? Yes ☐ No ☐	Time /date returned:
Has information been obtained from witnesses regarding the injury or exposure	☐ Yes ☐ No
Was there a safety hazard involved in this incident?	☐ Yes ☐ No
Has the safety hazard or unsafe condition been corrected?	☐ Yes ☐ No
If yes, explain action taken:	
How could injury or exposure have been prevented?	
What action have you taken to prevent reoccurrence?	
Supervisor's Name (Print):	Phone:
Supervisor's Signature:	Date: