



SAN MATEO UNION HIGH SCHOOL DISTRICT

OCCUPATIONAL ACCIDENT REPORT

EMPLOYEE INFORMATION

Employee Name: _____
Supervisor Name: _____
Time work began: _____

Job Title: _____
School Site: _____
Regular Schedule: _____

Important: Failure to report occupational injuries in a timely manner and/or failure to comply with the District's policies for medical treatment of occupational injuries could result in delay of any possible workers' compensation claim benefits. Workers' compensation claims may be subject to investigation by the insurance carrier. The employee must be treated by the District's designated medical facility if a physician was not previously pre-designated. **Any person who makes or causes to be made any knowingly false or fraudulent material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.**

INCIDENT INFORMATION

Does this injury require immediate medical attention? Yes No

Date of Incident: _____ Date Reported: _____ Time of Incident: _____

Who was incident reported to? _____

Were you performing your regular job duties at the time of accident? Yes No

If No, please explain: _____

Location where incident occurred: _____

Were there any witnesses to the accident? Yes No

If yes, please list witness names: _____

Were there any safety hazards, if yes explain: Yes No

How did the incident happen? Describe specific activity being performed, including tools, equipment, or materials used:

Describe body part(s) affected & how the body part is affected (i.e. bruising, sprain, etc.):

Any previous injuries to affected body part(s)? Yes No

If yes, please explain: _____

Any previous workers compensation claims: Yes No Details: _____

Additional Concerns: _____

Employee Signature

Reviewers Signature



1-877-518-6702
Use Search Code:
SMCS14