Print Form

SCHOOLS OF TULARE COUNTY
SUPERVISOR'S FIRST REPORT OF INJURY/ILLNESS/ACCIDENT
(Note: Box Numbers Correspond with 5020 Report)

EMPLOYER/SCHOOL DISTRICT
Tulare County Office of Education, 2637 W. Burrel Ave., Visalia, CA 93291

1. SCHOOL/SITE NAME & ADDRESS (Number, Street, City, Zip)	1A.SITE PHONE NUMBER
Administration	

7. EMPLOYEE NAME	8. SOCIAL SECURITY NUMBER	9. DATE OF BIRTH (MM/DD/YY)

10. HOME ADDRESS (Number, Street, City, Zip)	10A. PHONE NUMBER

11. SEX ☐ M ☐ F	12. Assigned Job Title - (NO Initials, abbreviations or numbers)

17. DATE OF INJURY OR ONSET OF ILLNESS (MM/DD/YY)	18. TIME INJURY/ILLNESS OCCURRED	19. TIME EMPLOYEE BEGAN WORK	21. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY?
	_____A.M. _____P.M.	_____A.M. _____P.M.	☐ YES ☐ NO
22. DATE LAST WORKED (MM/DD/YY)	23. DATE RETURNED TO WORK (MM/DD/YY)	27. DATE OF SUPERVISORS KNOWLEDGE OF INJURY (MM/DD/YY)	24. IF STILL OFF WORK, MARK SPACE WITH CHECK MARK ☐

29. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS IF AVAILABLE, e.g. second degree burns on right arm, tendonitis of left elbow, lead poisoning

30. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (No., Street, City)	30B. ON EMPLOYER'S PREMISES?
Administration	☐ YES ☐ NO

31. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g. shipping dpt., playground, lunchroom, classroom, restroom, etc.	32. OTHER WORKERS' INJURED/ILL IN THIS EVENT?
Administration	☐ YES ☐ NO_____PERSON

33. EQUIPMENT, MATERIALS AND/OR CHEMICAL THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g. Kitchen utensils, welding torch, scaffold

34. SPECIFIC ACTIVITY EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED e.g., mopping floors, loading food onto truck

35. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS, SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS e.g. custodian went to inspect overflowing sinks and toilets in the restrooms. He/she slipped on wet floors. As he/she fell, he hit his head on the floor and cut head. (USE SEPARATE SHEET IF NECESSARY).

DID EMPLOYEE GO TO DOCTOR?	36. IF YES, NAME AND ADDRESS OF PHYSICIAN/HOSPITAL	36A. PHONE #
_____☐YES _____☐NO	Kaweah Delta Urgent	

SUPERVISOR'S COMMENTS/REQUEST FOR INQUIRY

1. WERE THERE ANY WITNESSES TO INCIDENT? (Names)	1A. PHONE #	2. DATE DWC-1 GIVEN TO EMPLOYEE (MM/DD/YY)

3. WAS FIRST AID ADEQUATE TREATMENT?	4. DID AN UNSAFE CONDITION CONTRIBUTE TO THE INCIDENT?	4A. DID AN UNSAFE ACTION CONTRIBUTE TO THE INCIDENT?	5. IF YES TO 4 OR 4A, PLEASE EXPLAIN:
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	

6. WHAT CORRECTIVE ACTION HAS BEEN TAKEN TO AVOID SIMILAR INCIDENTS?	7. DOES EMPLOYEE HAVE ANY PRE-EXISTING INJURIES OR CONDITIONS? If yes, Explain:

8. DOES EMPLOYEE HAVE ANY OTHER EMPLOYMENT? (Name & Address of other employer)

9. COMMENTS

SIGNATURES REQUIRED

1. EMPLOYEE SIGNATURE/DATE	2. SUPERVISOR'S SIGNATURE/DATE

COMPLETE SAME DAY OF INCIDENT

3. PRINT SUPERVISOR'S NAME

Site Location: Complete Supervisor's Report of Injury, Fax, Followed-Up with Hard Copy to District Office
District Office: Complete 5020 Report Online –**FAX THIS FORM TO BUCKMAN-MITCHELL, INC. (KELLY) (559) 741-4437**
MAIL TO KEENAN & ASSOCIATES, P.O. BOX 1538, RANCHO CORDOVA, CA 95741