



- ❖ Complete all sections of the Supervisor's Report of Injury/Illness - Form 78 and fax to Risk Management at FAX (858) 627-7353 or scan and email to risk-management@sandi.net. Do not wait for the principal/department head's signature.
- ❖ Use additional pages as needed to provide all pertinent information regarding this employee's injury/illness.
- ❖ Contact Risk Management at (858) 627-7347 or risk-management@sandi.net to verify receipt of your report.
- ❖ Print and fax or scan/email a copy Supervisor's Report of Injury/Illness with Principal/Department Head's signature to Risk Management.

IMPORTANT: The site is required to call CalOSHA at (619) 767-2280 within 8 hours of the injury in the event of a serious injury or illness defined as requiring inpatient hospitalization for other than medical observation, or in which an employee suffers a loss of any member of body, or suffers any serious degree of permanent disfigurement. Failure to do so may result in a fine of up to \$5,000 to the site.

Employee Information							
Employee's First & Last Name		Position Title		School/Department	Location #	Work Phone #	Ext
Employee's Mailing Address (not SDUSD)			City	Zip Code	SDUSD Employee ID #		Home Phone #
Scheduled Days at Site <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Sun Total Hours Worked Per Week _____			Start Time <input type="checkbox"/> am <input type="checkbox"/> pm		End Time <input type="checkbox"/> am <input type="checkbox"/> pm		Non-Employee <input type="checkbox"/> Volunteer (Registered) <input type="checkbox"/> Student Paid by SDUSD
Injury/Illness Information							
Date of Injury/Onset of Illness		Time Injury/Illness Occurred <input type="checkbox"/> am <input type="checkbox"/> pm		Witnesses <input type="checkbox"/> No <input type="checkbox"/> Yes, full name(s)			
What part of body is affected? <i>(Example: index finger, left ankle, upper back)</i>				What is the specific injury/illness? <i>(Example: cut, sprain, strain)</i>			
Describe How Injury/Illness Occurred. Describe sequence of events. Specify object or exposure which directly produced the injury/illness. <i>(Example: Employee was walking from the classroom to the administration office when she tripped over uneven pavement and fell on both knees)</i>							
Where did the injury/illness occur?							
School/Department:		Address:			City:		Zip Code:
Was Employee acting within the normal course of duties? <input type="checkbox"/> Yes <input type="checkbox"/> No (if No, explain)							
Any equipment, chemical, materials, etc. used at time of injury? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, explain)							
Are physical repairs necessary to site? <input type="checkbox"/> Yes <input type="checkbox"/> No (if Yes, explain)							
Was employee following safety procedure(s) when injury occurred? <input type="checkbox"/> Yes <input type="checkbox"/> No (If No, explain)							
Has corrective action been taken to prevent a recurrence? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, explain)							
Medical Treatment (Select One Below) - Employee receiving medical treatment may not return to work without a medical release.							
<input type="checkbox"/> NO Medical Treatment Sought							
<input type="checkbox"/> NO Medical Treatment Sought. Employee was seen by School Nurse. _____							
<input type="checkbox"/> YES, Medical Treatment Sought. Provide Medical Facility Name and Address _____							
<input type="checkbox"/> YES, Medical Treatment Sought. Employee has a Pre-Designation of Personal Physician Form on file with the Risk Management Department.							
Medical Facility & Physician's Full Name: _____							
Address:(Street, City, Zip) _____ Phone: _____							
Completed By: (Supervisor, not injured employee, to report work-related injury/illness)							
Print Name			Title			Work Phone #	Ext #
Date of Supervisor's Knowledge/Notice of Injury/Illness			Signature			Date Signed	
Principal/Department Head							
Print Name			Title		Signature		Date Signed