Victor Valley College
Employee Statement of Occupational Injury/Illness

This form is to be filled out by the employee when an Injury/Illness occurs.
In case of emergency call 911 otherwise call Company Nurse 877-518-6702 VVC code# QS648

EMPLOYEE INFORMATION

Employee Name: ____________________________________Job Title: ______________________________

☐ Full time, ☐ Part time/Hourly, ☐Vocational Student, ☐Volunteer; Supervisor: ___________________

Home Address/City/Zip Code: ____

Phone Number: __(_ __)_________________________ Date of Birth:_________________________

Date of Hire:____ Social Security #______________________

Start Time:_______________End Time:________________ Work Site:___________________________

# of Hours Worked Daily:___________ # of Days Weekly:___________ # of Hours Weekly:__________

INJURY/ILLNESS INFORMATION

Type of Incident: ☐ Injury ☐ Illness Date of Injury/Illness: _________Time of Injury/Illness: _________

Date Reported: _________How did you report the injury/illness? ☐ In person ☐ Phone ☐ Other: _______

Who did you report the injury/illness to? ____

Did anyone witness the injury? ☐ Yes ☐ No If so, Who:_______________________________________

Was anyone else injured? ☐ Yes ☐ No If so, Who:____

Where did injury/illness occur? (Be specific, including building & room number, if applicable)

____

What were you doing when the injury/illness occurred? (state equipment, materials and/or chemicals being used)

____

Describe how the injury/illness occurred: (Example: I was walking down the stairs, tripped & fell injuring right knee on the cement; I was lifting a box, felt sharp pain in lower back.)

____

What body part(s) were injured? ____

Was there anything that could have been done to prevent the injury? ______________________________

MEDICAL TREAMENT

Have you called Company Nurse? ☐ Yes ☐ No

Are you seeking medical treatment at this time? ☐ Yes ☐ No (if no, fill out declination of treatment)

EMPLOYEE SIGNATURE

I acknowledge that my employer has provided me with a DWC-1. If I wish to file a workers' compensation claim for this incident, I will need to complete the form and return it to my supervisor or Human Resources.

This is an accurate statement, in my own words, which describes my accident and/or injuries.

Warning: Any person who makes a false or fraudulent written or oral statement for the purpose of obtaining workers' compensation benefits or payments is guilty of a felony. Penalties include fines, imprisonment or both.

______________________________	______________________________	____________________
(Signature)	(Please Print Name)	(Date)