GROSSMONT-CUYAMACA
COMMUNITY COLLEGE DISTRICT

Injury Illness / Accident Report

☐ **Grossmont Campus** ☐ **Cuyamaca Campus**

☐ Student ☐ Student Worker
☐ Employee ☐ Public

Confidential: Pursuant to Education Code, Privacy of Pupils, Section 49073.5 et seq.

Name: Last First MI

Address: Phone:

Social Security Number: | Date of Birth | Date/Time of Injury: | Did injury result from violence or aggression? ☐Yes ☐No

Is injured party covered by insurance? ☐Yes ☐No
If yes, list insurance carrier:

Was there a violation of a school rule by injured party or anyone else? ☐Yes ☐No

Was there anyone else involved? ☐ No One ☐ Another Student ☐ Visitor Whom:

Witnesses	Phone Number	Campus Police Called ☐ Yes ☐ No
		Instructor in charge/Dept or Class:

Cause of Injury

- ☐ Animal/Insect
- ☐ Vehicle
- ☐ Another Student
- ☐ Equipment
- ☐ Other (Describe):
- ☐ Food/Drink
- ☐ Hand Tool
- ☐ Building
- ☐ Chemicals

Nature of Injury

- ☐ Abrasion
- ☐ Bite/Sting
- ☐ Bruise
- ☐ Burn
- ☐ Chemical Exp
- ☐ Cut
- ☐ Dislocation
- ☐ Foreign Body
- ☐ Other (Describe):
- ☐ Fracture
- ☐ Internal
- ☐ No Visible Injury
- ☐ Pain
- ☐ Puncture
- ☐ Redness
- ☐ Sprain/Strain
- ☐ Swelling

Part of Body ☐ Left ☐ Right

- ☐ Ankle
- ☐ Arm
- ☐ Back
- ☐ Chest
- ☐ Chin
- ☐ Ear
- ☐ Ear
- ☐ Eye
- ☐ Face
- ☐ Finger
- ☐ Foot
- ☐ Groin
- ☐ Hand
- ☐ Head
- ☐ Hip
- ☐ Knee
- ☐ Leg
- ☐ Lip
- ☐ Mouth
- ☐ Neck
- ☐ Nose
- ☐ Shoulder
- ☐ Stomach
- ☐ Tooth
- ☐ Wrist
- ☐ Other (Describe):

Briefly describe **How** and **Where** the injury occurred:
(Injured Party's Statement):

Supervisor: _____ Department: _____ Ext.: _____

Did injury occur while performing work duties? ☐ Yes ☐ No Were safety devices provided? ☐ Yes ☐ No

When did supervisor know of injury?

Was first aid given?: ☐ No ☐ Yes (Describe): Provided by:

Date person given DWC 1 Form (Workers Comp) if needed: _____
Date form was returned: _____

Injured Party was:
☐ Returned to Class ☐ Taken to Hospital ☐ Sent Home ☐ Went Home ☐ Other (specify):

What action has been taken to prevent accident from recurring?

By signing below I acknowledge that I have read and received HIPPA/District information claim instructions.

Injured Party's Signature: Date:

Report Completed by supervisor: | Title: | Date: | Phone:

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Carbonless Form WHITE: Risk Management; YELLOW: Health Services /Generator; PINK: Supervisor copy