San Diego Unified SCHOOL DISTRICT

Risk Management Department

Supervisor's Report of Injury/Illness - Form 78

(For supervisor, not injured employee, to report work-related injury/illness)

Completing this form is not an admission of SDUSD liability

Reference: Administrative Procedure 5170

- 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: ☐Mon ☐Tues ☐Wed ☐Thurs ☐Fri ☐Sat ☐Sun

Total Hours Worked Per Week _____

Start Time: ☐ am ☐ pm

End Time: ☐am ☐pm

Non-Employee: ☐Volunteer **(Registered)** ☐Student Paid by SDUSD

Injury/Illness Information

Date of Injury/Onset of Illness	Time Injury/Illness Occurred	Witnesses
	☐am ☐pm	☐No ☐Yes, full name(s)

What part of body is affected? ***(Example: index finger, left ankle, upper back)***	What is the specific injury/illness? ***(Example: cut, sprain, strain)***

Describe How Injury/Illness Occurred. *Describe sequence of events. Specify object or exposure which directly produced the injury/illness.*

(Example: Employee was walking from the classroom to the administration office when she tripped over uneven pavement and fell on both knees)

Where did the injury/illness occur?

School/Department: Address: City: Zip Code:

Was Employee acting within the normal course of duties? ☐Yes ☐No (if No, explain)

Any equipment, chemical, materials, etc. used at time of injury? ☐Yes ☐No (If Yes, explain)

Are physical repairs necessary to site? ☐Yes ☐No (if Yes, explain)

Was employee following safety procedure(s) when injury occurred? ☐Yes ☐No (If No, explain)

Has corrective action been taken to prevent a reoccurrence? ☐Yes ☐No (If Yes, explain)

Medical Treatment (*Select One Below*) - Employee receiving medical treatment may not return to work without a medical release.

☐ NO Medical Treatment Sought

☐ NO Medical Treatment Sought. Employee was seen by School Nurse. _____

☐ YES, Medical Treatment Sought. Provide Medical Facility Name and Address _____

☐ 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)* *(Employees are not to be given a copy of the 78)*

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

*Revised July 2023