PRINT FORM CLEAR FORM *(When entering information, click in first space and tab through form)*
Press <Shift + Tab> to go to previous field.

EHS 001 09 1

DEL MAR COLLEGE
ACCIDENT/INJURY/ILLNESS REPORT

Point and click on space provided or press <Enter>

☐ **Employee Injury/Illness**

Employee Information

First Name M.I. Last Name	☐Male ☐Female	Colleague ID#
Date of Birth	Date Hired	Home Phone *(Enter without dashes)*
Mailing Address	City, State	ZIP Code
Marital Status ☐ Married ☐ Widowed Separated ☐ Single ☐ Divorced	Spouse's Name	Number Dependent Children
Department	Occupation	Supervisor

Description of Work-Related Injury/Illness

Date / / Time : ☐ AM ☐PM	Was employee performing his/her regular duties? ☐ Yes ☐No	Able to return to work? ☐Yes ☐No Date: / / Time: : ☐AM ☐PM
Specific Location		
Describe fully what happened and why the injury/illness occurred If additional space is needed, please attach additional sheet of paper.		

Nature of injury/illness	Body part(s) injured or exposed
Names of witnesses *(Enter without dashes)* Phone Numbers 1. 2.	Name & address of physician If hospitalized, hospital name City

To the best of my knowledge, this report is ☐correct ☐incorrect (attach separate sheet)

Employee Signature _____ Date _____

To the best of my knowledge, this report is ☐correct ☐incorrect (attach separate sheet)

Supervisor Signature _____ Date _____

This form must be completed and sent to the Environmental Health & Safety Office immediately.