County of San Bernardino
Department of Behavioral Health

Investigation of Workplace Incidents, Occupational Injury, Illnesses and Hazardous Exposure

Clinic/Facility: _____

Facility Address: _____

Name of Injured Employee: _____

DOB: _____ **Employee #:** _____ **Class:** _____ **Position #:** _____

Phone #: _____ **Date of Hire:** _____ **Soc. Sec. #:** _____

Date of Accident/Illness/Hazardous Exposure: _____ **Hour:** _____ **AM** ____ **PM** ____

Description of Injury/Illness/Hazardous Exposure: _____

_____

_____

Who gave first aid, (if any)? _____

Name and address of Physician: _____

_____

Did injured employee leave work? _____ **Date:** _____ **Time:** _____ **AM** ____ **PM** ____

Did injured employee return to work? _____ **Date:** _____ **Time:** _____ **AM** ____ **PM** ____

Was injured employee acting in a regular line of duty? _____

Names of witnesses: _____

Where and how did accident occur? _____

_____

_____

What steps have been taken to prevent similar accident/illness? _____

_____

_____

_____

Supervisor's comments: _____

_____

_____

_____ _____

Supervisor's signature **Date**