REPORT OF INDUSTRIAL INJURY
MCCCD Employee & Supervisor

Name of Injured Worker: ____
Last First M.I.

Employee I.D.#: ____________________ Position Title: ________________________

Home Address: ____
Street City State Zip

Phone Number(s): ____

College or Location: _________ Hours Worked per Day: _________ Per Week: _________

DATE OF INJURY: __________ Time of Injury: __________ AM or PM

Address or location of accident: ____

Did you stop working immediately? ________________ When did you stop? __________

When did you return to work? _____________ Regular Work? ______ Other Work? ______

Names of persons who saw the accident.

Name: ________________ Address: __________________ Phone # __________

Name: ________________ Address: __________________ Phone # __________

Was accident caused by another person? _______ If so, Whom? ____________________

Name of machine or tool that may have caused the accident: ________________________

State how the accident happened: ____

____

____

Body part injured: ______________ Describe the injury (cut, bruise, etc.): ______________

Were you treated? If so, Where?____

Who treated you? ____
Name Phone#

Was a College Safety Report completed? _______ Copy attached? ____________________

Date reported to Supervisor: ____

Employee's Name: ________________ ________________ ______________
Print *Signature/Date Phone#

Supervisor's Name: ________________ ________________ ______________
Print *Signature/Date Phone#

Or Other Manager: ________________ ________________ ______________
Print *Signature/Date Phone#

***Please do not hold up report due to signatures. Process and follow up with signatures at a later date.**

Attach to Employer's Report of Injury (completed by college Worker's Compensation Representative), and send to: MCCCD Compensation Dept., 2411 West 14th St., Tempe, AZ 85281-6942
Phone 480 731-8457, FAX 480 731-8484

Billing Address: TriStar Risk Management, P.O. Box 30696, Phoenix, AZ 85046, Phone 602 331-3511