SCOTTS VALLEY FIRE PROTECTION DISTRICT

WORK RELATED INJURY REPORT

SVFPD Claim#: _____

SECTION 1: Complete for all injuries Date Reported: _____ Time Reported: _____

Employee: _____ Job Title: _____

Date of Injury: _____ Time of Injury: _____ Immediate Supervisor: _____

Address/Location Injury Occurred: _____

Job/Activity at Time of Injury: _____

Cause of the Injury: _____

_____

_____

Witnesses: _____ _____ _____

Unsafe Act/Corrective Action Taken: _____

_____

_____

Additional Supervisor Notes: _____

_____

Medical Evaluation Completed: ☐ Yes ☐ No Provider: ☐ SCOMC ☐ Dominican ER Date: _____

Employee was provided Workers Comp Claim Form DWC 1: ☐ Yes Date: _____

Employees Signature: _____ Date: _____

Supervisors Signature: _____ Date: _____

SECTION 2: Complete if Workers' Compensation forms were not returned at the time of injury

Employee Signature: _____ Date: _____

Additional Employee Notes: _____

_____

The Scotts Valley Fire Protection District is not aware of any issues regarding this injury: ☐ Yes ☐ No

Fire Chief Signature: _____ Date: _____