IN CASE OF WORKPLACE INJURY

ACCION a seguir en caso de un accidente en el trabajo

COMPANY NURSE
Because Accidents Happen

AVAILABLE 24 HOURS A DAY

1-833-572-0746

Employer Name (Nombre De Compania)	Search Code (Código Del Búqueda)
Barstow Community College District	QT822

1. **Injured worker notifies supervisor.**
   Empleado lesionado notifica a su supervisor.

2. **Supervisor/Injured worker immediately calls injury contact center.**
   Supervisor / Empleado lesionado llama de imediato al centro de contacto para lesiones.

3. **Company Nurse gathers information over the phone and helps injured worker access appropriate medical treatment.**
   Company Nurse obtiene información por teléfono y asiste al empleado lesionado en adquirir el tratamiento médico adecuado.

NOTICE TO EMPLOYER/SUPERVISOR: Please post copies of this poster in multiple locations within your worksite. If the injury is non-life-threatening, please call Company Nurse prior to seeking treatment. Minor injuries should be reported prior to leaving the job site, when possible.

INCIDENT/INJURY REPORT FORM

Date of Incident _____ Time of Incident _____am / pm

Name of Person Filing Report _____ ☐ Security ☐ Staff ☐ Student

Name of Person Involved _____ Student I.D. #_____

Phone # _____ D.O.B. _____

Address _____City _____Zip_____

Emergency Contact_____ Phone ( )_____

Insurance Company *(complete if covered by insurance; otherwise write "None")*_____

_____

PLACE OF INCIDENT

Classroom (specify)_____ Other Location (if Off Campus, specify)_____

DESCRIPTION OF INCIDENT AND/OR INJURY

Please provide specific details regarding the incident or injury, such as names, places, the time of events, and B numbers of any students involved. In the case of an injury, please also specify any unsafe conditions, actions, tools or equipment involved. *Please attach a separate sheet if needed.*

_____

_____

_____

_____

_____

_____

ACTIONS TAKEN

Describe Action Taken _____

_____

_____

Was a parent or other individual notified? No____ Yes____ When?_____ How?_____

Name of individual notified_____ By Whom?_____

Witness: Name_____ Phone_____

Sent to Hospital (name)_____Referral to Physician_____

Refused Treatment_____

Signed: _____ **Date:** _____

Rev. 04/2025

Send Form to: Vice President of Administrative Services (VPAS) Office