CHINO VALLEY
UNIFIED SCHOOL DISTRICT

5130 Riverside Drive, Chino, CA 91710

RISK MANAGEMENT

Employee Statement

Employee's name:		
Home address:		
Phone number:		
Social security number:	Date of birth:	Date of hire
Supervisor:	School Site/Department:	Occupation:
Employee status (full time, part time, substitute):	Employee work hours:	Employee's gross hourly/yearly wage:
Date of injury:	Time of injury:	Time employee began work:
Date last worked:	Date returned to work:	Were there any witnesses? If yes, please provide their name:
Department where injury occurred:	Date of employer's knowledge of injury:	Date employee was provided claim form:
Describe how the injury happened:		
List in detail all the body parts injured:		
What caused you to have the injury/incident:		
Were you previously injured before the incident occurred, or did anything else affect your performance?		
How do you feel now?		
This is an accurate statement, in my own words, which describe my incident and injuries: Employee Signature**:**		Date:

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Clinic Questionnaire

Employee's name	Date of Injury:
What clinic did you go to?	
Did you like the clinic? ☐Yes ☐No	
Was the clinic facility clean and organized? ☐Yes ☐No	
Was the clinic staff friendly and helpful? ☐Yes ☐No	
How long did you wait to receive medical treatment?	
Was your diagnosis explained to your satisfaction? ☐Yes ☐No	
Did you like your doctor? ☐Yes ☐No	
Was a follow-up scheduled? ☐Yes ☐No If yes, did you feel it was necessary?	
Did you feel you should have additional treatment? ☐Yes ☐No If yes, what kind?	

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Supervisor Statement

Name of injured worker:		
Occupation:	Location where injury occurred:	
Date of injury:	Time of injury:	Date/time reported to you:
Task being performed when accident occurred: (Please be specific, identify tools, equipment or material the employee was using)		
Name (s) of witness:		
Accident resulted in: ☐Injury ☐Fatality ☐Property Damage		
First aid given? ☐Yes ☐No	Medical treatment required? ☐Yes ☐No	Workdays lost:
Describe how the accident occurred:		
What body part was injured:		
What actions, events, or conditions contributed most directly to this accident?		
What actions have or will be taken to prevent reoccurrence?		
Supervisor Signature:	Date:	

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Witness Statement
(Please complete the following in your own words)

Name of injured worker:		
Witness name:		
Home address		
Telephone number:	Occupation:	School site/department:
Date of injury:	Time of injury:	Where did the injury occur?
Describe what you saw:		
In your opinion, what body parts were injured?		
Who or what caused the injury/incident?		
Was there anything that could have been done to prevent the injury?		
Witness Signature:	Date:	