

SUPERVISOR'S REPORT OF WORK-RELATED ACCIDENT/ILLNESS

Record as an "Incident Only"

File a Workers' Compensation Claim

EMPLOYEE INFORMATION

Employee Name:	Date of Birth:
Address:	Best contact number:
City/State/Zip:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Department:	Department Phone:
Supervisor:	Supervisor Phone:

TYPICAL WORK SCHEDULE

Days per week: _____ # hours per day: _____ # Hours per wk: _____ Work Schedule: _____ a.m. /p.m. to _____ a.m. /p.m. (circle a.m. or p.m.)

INCIDENT INFORMATION

Date of Injury:	Witnesses? <input type="checkbox"/> No <input type="checkbox"/> *Yes - Complete part "B"	Were Campus Police Notified? <input type="checkbox"/> No <input type="checkbox"/> Yes
Time of Injury: _____ a.m. _____ p.m.	If employee died, date of death:	
Supervisor date of knowledge:	Was another person responsible? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Date claim form given to employee:	Were other worker's injured? <input type="checkbox"/> No <input type="checkbox"/> Yes	

What was the injury or illness? Tell us the part of the body that was affected and how it was affected; be more specific than "hurt", "pain", or "sore." Examples: "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."

What was employee doing just before the incident occurred? Describe the activity, as well as the tools, equipment or material the employee was using. Be specific. Examples: "Climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."

What happened? Describe how injury/illness occurred (if more space is needed, please attach separate sheet of paper):

What object or substance directly harmed the employee? Examples: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, leave it blank.

Did injury/illness occur on employer's premises? <input type="checkbox"/> No <input type="checkbox"/> Yes	Location/Department where injury/illness occurred:
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LOST TIME

Did the employee miss any work related to the injury? No Yes

Returned to work? No Yes

If yes, first date missed work? _____

Date returned to work: _____

MEDICAL INFORMATION

Was employee treated in an emergency room? No Yes

Medical treatment sought at: Sharp Rees-Stealy Occupational Medicine *Other

**If other, please complete the following:*

*Physician/Facility Name:	*Address:
*City/State/Zip:	*Phone:

If hospitalized, please complete: Was employee hospitalized overnight as an in-patient? No Yes

Facility Name:	Address:
City/State/Zip:	Phone:

B. Witnesses: _____

Completed by: _____

(print/type name/title)

Signature: _____

Date: _____

Fax forms within 24 hours of notification to 619-594-4013. Questions? Please call 619-594-1142 or 619-594-1144.

Note: Completing this form is not an admission of liability. A Claim form must be given to the injured worker within one working day of your knowledge of occupational injury or illness which results in lost time or medical treatment. This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (B)(6)-(10). EQUIVALENT TO THE CAL/OSHA FORM 301