

SUPERVISOR'S REPORT OF WORK-RELATED ACCIDENT/ILLNESS

SUPERVISOR IS TO COMPLETE THIS FORM. UNDER NO CIRCUMSTANCES IS THE INJURED EMPLOYEE TO COMPLETE THIS FORM

Name: _____
Address: _____
City/State/Zip: _____
Date of Hire: _____
Department: _____
Dept. Manager: _____
Supervisor: _____

Employee # : _____
Home Telephone: _____
Work Telephone: _____
Sex: Male ___ Female ___
Dept. Ext.: _____
Mgr. Ext.: _____
Sup. Ext.: _____

Employee Usually Works: No. Days per week: _____ No. Hours per day: _____ No. Hours per week: _____
Work Schedule: _____ am _____ pm to _____ am _____ pm

Date of Injury: _____
Time of Injury: _____ am _____ pm
Your date of knowledge: _____
Date claim form given to employee: _____

Witnesses? No *Yes - Complete part "B"
If employee died, date of death: _____
Was another person responsible? No Yes
Were other worker's injured? No Yes

Was Campus Police
Notified?
 No 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 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? Yes No
Location/Department where injury/illness occurred: _____

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

Lost time? No Yes* - *Dr. note required*
*Date last worked: _____

Still off work? Yes No* - *Dr. release required*
*Date Returned to work: _____

CHECK APPROPRIATE BOX(S):

No Medical Treatment Sought by Employee
Medical treatment at: SDSU HEALTH SERVICES SHARP REES - STEALY OCCUPATIONAL MEDICINE *OTHER
Was employee treated in an emergency room? Yes No

Please complete the following:

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

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

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

List name(s) of witnesses:

Phone: _____

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).