

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

EMPLOYEE INFORMATION

Name: _____ Employee # : _____
Address: _____ Home Telephone: _____
City/State/Zip: _____ Work Telephone: _____
Date of Hire: _____ Sex: Male ___ Female ___
Department: _____ Dept. Ext.: _____
Dept. Manager: _____ Mgr. Ext.: _____
Supervisor: _____ Sup. Ext.: _____

WORK SCHEDULE

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

ACCIDENT INFORMATION

Date of Injury: _____ Time of Injury: _____ am _____ pm Your date of knowledge: _____ Date claim form given to employee: _____	Witnesses? <input type="checkbox"/> No <input type="checkbox"/> *Yes - Complete part "B" If employee died, date of death: _____ Was another person responsible? <input type="checkbox"/> No <input type="checkbox"/> Yes Were other worker's injured? <input type="checkbox"/> No <input type="checkbox"/> Yes	Was Campus Police Notified? <input type="checkbox"/> No <input type="checkbox"/> Yes
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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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Location/Department where injury/illness occurred:
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What happened? Describe how injury/illness occurred (if more space is needed, please attach separate sheet of paper):

LOST TIME

Lost time? <input type="checkbox"/> No <input type="checkbox"/> Yes* - Dr. note required *Date last worked: _____	Still off work? <input type="checkbox"/> Yes <input type="checkbox"/> No* - Dr. release required *Date Returned to work: _____
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MEDICAL INFORMATION

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: _____

A. WITNESSES

List name(s) of witnesses:

Completed by: (Print/Type name/title)	Signature	Date
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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).