



SUPERVISOR'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

California law requires an employer to report within five days every injury or occupational illness which:

- (1) results in time lost beyond the day of injury or
(2) requires medical treatment other than first aid.

This report is required by our Third Party Administrator (TPA) and the Department of Industrial Relations. Send ONE COPY to Human Resources Management (HRM), Attn: Workers' Compensation Coordinator, Adm. 606 (Mail Code 8534-01). HRM will prepare and submit the official report to the TPA. Make and retain a copy of the report for your file. FATAL or SERIOUS injuries/illnesses must be reported IMMEDIATELY by telephone and on this form to Human Resources Management, who will then report to the TPA and the Division of Industrial Safety as required by law.

If you have any questions, please call extension 3657.

PLEASE REPORT ALL INJURIES (no matter how trivial) WITHIN ONE WORKING DAY TO YOUR EMPLOYER.

FILING THIS REPORT IS NOT AN ADMISSION OF LIABILITY

Part A - PERSONAL INFORMATION

Name of the Injured: Social Security Number:
Home Address (Number and Street, City, Zip):
Home Phone Number: Birth Date:

Part B - EMPLOYEE STATUS

Classification: Department:
Supervisor: Hire Date:
Status: Full-Time Part-Time Sex: Male Female
Salary: \$ per month or \$ per hour Hours Worked: Daily Weekly

Part C - INJURY/ILLNESS

Date: Time: a.m./p.m. Date Employee Reported Injury:

Witnesses (Name and Telephone Numbers):
1. 3.
2. 4.

Where did injury/illness occur?
What was the employee doing when injured?

Describe the nature of the injury/illness.

PLEASE ANSWER ALL QUESTIONS

Part C (Continued)

Describe the part(s) of the body injured. _____

Was another person responsible? Yes No If yes, explain. _____

Part D – **MEDICAL TREATMENT**

Where did employee receive treatment:

- CSULA Student Health Center
- Concentra Medical Group
- Hospital: Name _____
Address _____
- Other: Name _____
- Declined Medical Care

Part E – **RETURN TO WORK**

Did the employee lose at least one (1) full day of work after the date of injury/illness? Yes No

Did the employee return to work? Yes (returned to work on _____) No

What type of work did you return to: Regular Modified

If you were unable to perform full duty, what type of temporary-modified work was made available to you?

Part F – **ACCIDENT PREVENTION**

Describe the workplace and conditions which may have contributed to the injury/illness and safety devices present :

What recommendations would you suggest which may correct the condition(s) and/or prevent future injuries/illnesses of this type?

Supervisor's Signature: _____ Supervisor's Name (print): _____

Position Title: _____ Extension: _____ Date: _____