HUMAN RESOURCES MANAGEMENT

EMPLOYEE'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

1. Notify your immediate supervisor as soon as possible of any injury/illness sustained during the course of your work with Cal State L.A.

2. Obtain medical from
   - Cal State L.A. Student Health Center; or
   - Concentra Medical Group or
   - Your personal physician
     - Authorized only if you have submitted a Designation of Physician form to Human Resources Management (HRM) before your date of Injury.

3. Within one working day, complete and return to HRM and provide a copy to your immediate supervisor:
   - Employee's Report of Occupational Injury/Illness

4. Continue with medical treatment as prescribed by the treating medical provider. After each medical visit, submit a copy of your medical status documents to:
   - Your immediate supervisor, and
   - Human Resources Management

Upon receipt of the appropriate forms, Human Resources Management will coordinate the claim processing with the University's insurance provider, the employing department, the medical provider and the employee. Should you require further assistance with this form, please contact your workers' compensation coordinator at extension 3657.

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: _____

Salary: $ _____ per month or $ _____ per hour Sex: Male ☐ Female ☐

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 were you doing when the injury/illness occurred? _____

How did the injury/illness occur? _____

Describe the nature of the injury/illness. _____

_____

_____

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

Did you 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?

_____

_____

_____

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

Working Title: _____ Extension: _____ Hire Date: _____