SUPERVISOR'S REPORT OF EMPLOYEE INJURY

CALIFORNIA STATE UNIVERSITY, STANISLAUS
Human Resources, MSR320 | One University Circle | Turlock, CA 95382| Phone (209) 664-6921 Fax (209) 664-7182

ADMINISTRATIVE USE: OSHA ☐ Record Only ☐ WC Claim#

To be completed by Supervisor/Manager for all injuries/illnesses to employees including student assistants, volunteers, and part time employees. Fill out **ALL** information below and return to the Workers' Compensation Coordinator, MSR340. Provide employee "Workers' Compensation Claim Form (DWC1)" including Notice of Potential Eligibility immediately upon knowledge of injury or illness.

Complete this form in its entirety and submit within 24-hours of the injury

A. EMPLOYEE INFORMATION

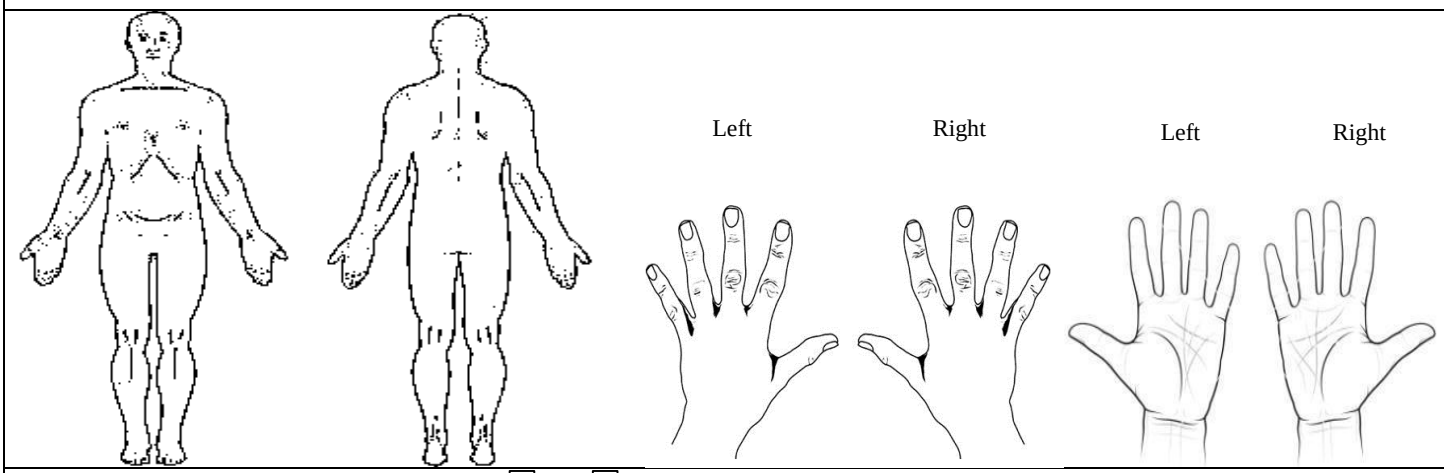
Name (Last, First):	Bargaining Unit:	Date of Birth:	Extension:
Street (Home)	City	State	Zip Code
Home Number	Cell Number	Sex: ☐ Male ☐ Female	Date of Hire:
Campus Division ☐ AA ☐ SA ☐ UA ☐ BF ☐ FA/HR	Department	Supervisor Name	Supervisor Extension
Job Title	☐ FT ☐ PT ☐ SA ☐ Student in Field Work	☐ Volunteer/Seasonal (Attach Volunteer Authorization Form)	
Shift Time ------ ☐ AM ☐ PM ☐ AM ☐ PM	Work Days ☐ Su ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ Sa		

B. INJURY/ILLNESS INFORMATION

Date of Injury/Illness:	Time of Injury/Illness:	Specific Location of Injury/Incident occurred (on/off campus):
Date you were informed of injury/illness:	Name of Witness(s)/ Phone#:	

Date you gave employee "Workers' Compensation Claim Form (DWC1)" including Notice of Potential Eligibility:

Indicate Nature of Specific injury/illness (cut, sprain, foreign body, burn, carpal tunnel); part of body affected and please circle all injured areas:



Were other employees injured in this event? Yes ☐ No ☐ (If yes, complete a separate report for each employee)

Were non-employees injured in this incident? Yes ☐ No ☐ (If yes, University Police should be contacted to prepare a report: (209) 667-3114)

Was there any property damage during this incident? Yes ☐ No ☐

If yes, describe the property damage: _____

Did this employee injury/illness occur during the course of the employee's normally assigned duties? Yes ☐ No ☐

What was employee doing just before the incident occurred? Fully explain sequence of events that resulted in injury/illness. Describe the activity as well as the tools, equipment, or material the employee was using. Be specific. *Examples:" materials", "spraying chlorine from hand sprayer"; "daily computer key-entry"*:

Describe what happened. How did the injury or illness occur? Describe the actions, conditions, and decisions that led to the incident. *Examples: "When ladder slipped on wet floor, worker fell 20 feet"; Worker was sprayed with chlorine when gasket broke"; developed soreness in wrist over time."*

Describe work place and conditions which contributed to the accident or object or substance that directly harmed employee. Was Personal Protective Equipment (PPE) in use?

What object or substance directly harmed the employee? *Examples: "concrete floor; "chlorine"" radial arm saw."*

Were proper procedures being followed when the incident occurred? Yes ☐ No ☐ If no, explain

Does a written safe work practice for the task that was underway at the time of the incident exist? Yes ☐ No ☐

Was current, documented employee training provided for the task/procedure/equipment prior incident? Yes ☐ No ☐

What corrective action or preventative action was taken to prevent recurrence? Check as many as appropriate.

☐ Safety Guidelines Developed ☐ Employee Counseled
☐ Safety Training Scheduled ☐ Repairs Ordered/Made
☐ Personal Protective Equipment Ordered ☐ Other (attach separate page if necessary)

C. MEDICAL TREATMENT INFORMATION

Did injury result in disability beyond day of accident? ☐ Yes ☐ No

If "Yes", date last worked: _____ Date returned to work: _____
If employee died, when did death occur?

Medical Treatment by:

☐ Medical Treatment Declined ☐ Treated Self ☐ Personal Physician ☐ St. Josephs (Stockton) ☐ Emergency Room
☐ Sutter Gould (Turlock/Modesto) ☐ Other

☐ Pre-Designated Physician: _____(must have pre-designated physician form on file prior to injury)

☐ Employee was transported by ambulance to: Hospital: _____ Phone Number: _____

☐ Employee was hospitalized overnight as an in-patient

Name/Address of Treating Physician:	Phone Number:

Manager/Supervisor Signature: Date:

WC Coordinator/HR Rep Signature: Date:

Distribution: Return to HR: (1) Fax to (209) 664-7182; (2) Hand deliver to HR, MSR320; (3) Mail interoffice in a sealed confidential envelope; (4) Keep department copy on file