Cal State LA

HUMAN RESOURCES MANAGEMENT

EMPLOYEE'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

1. Notify yoiur 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 care from
   - Cal State L.A. Student Health Center; or
   - U.S. HealthWorks Medical Group or
   - Your personal physician (authorized only if you have submitted a Designation of Physician form to Human Resources Management Before your Date of Injury).

3. Within one working day, complete and return 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 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 (Names 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. _____

_____

(Over)

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
_____ U.S. HealthWorks 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: _____ Date: _____

HRM USE ONLY

Position Number: _____ Salary: $ _____ Hire Date: _____