Cal State LA HUMAN RESOURCES MANAGEMENT

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. The Department of Public Safety is responsible for making these reports to the Division of Industrial Safety when Human Resources Management is closed.

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?

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

Position Title: _____ Extension: _____ Date: _____