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 injured : _____ Employee ID Number: _____

Home Address (Number & 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 (Names and Telephone Numbers):

1 _____ 3 _____

2 _____ 4 _____

Where did injury/illness occur? _____

What was employee doing when injured? _____

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 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 the employee return to: _____ Regular _____ Modified

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

_____

_____

Arranged temporary-modified work for _____ day(s) beginning on _____

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: _____

HRM USE ONLY

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