

# EMPLOYEE / VOLUNTEER INJURY / ILLNESS REPORT

Date \_\_\_\_\_ OSHA Case# \_\_\_\_\_ Privacy Log# \_\_\_\_\_

**PART I – TO BE COMPLETED BY INJURED/ILL EMPLOYEE/VOLUNTEER (IF ABLE)**

Name (Last, First)		CWID (if known)		Date of Birth	Extension
Street (Home)		City		State	Zip Code
Division <input type="checkbox"/> AF <input type="checkbox"/> AA <input type="checkbox"/> SA <input type="checkbox"/> UA <input type="checkbox"/> IT <input type="checkbox"/> HR		Department		Supervisor Name	
Home Number or Cell		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date Hired	Shift Time: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	
Job Title		<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student Assistant <input type="checkbox"/> Volunteer		Work Days <input type="checkbox"/> Su <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F <input type="checkbox"/> Sa	
For volunteers: Who do you report to at CSUF?					

Describe the injury/illness, including what, where, why, how the injury/illness occurred: **(be as specific as possible)**

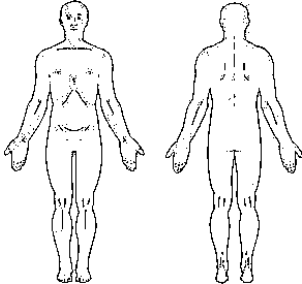




\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please circle all injured areas

		<p>Left</p> 	<p>Right</p> 	<p>Left</p> 	<p>Right</p> 	Name of Witness / Phone # 1.) _____ 2.) _____ 3.) _____
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Date of Injury/Illness	Time: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	Location	Date Reported to Manager/Supervisor	<input type="checkbox"/> <b>Medical Treatment Declined</b> <input type="checkbox"/> <b>Claim Form received</b> (only complete if treatment is needed)
Signature (injured employee)		Date	Report Completed By (un-injured party)	Date
				Phone Number

**PART II – TO BE COMPLETED BY SUPERVISOR (WITHIN 24 HRS OF KNOWLEDGE OF INCIDENT)**

Date of Injury/Illness	Time: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	Medical Treatment <input type="checkbox"/> Medical Treatment Declined <input type="checkbox"/> First Aid in Department <input type="checkbox"/> Brea Urgent Care <input type="checkbox"/> Sand Canyon <input type="checkbox"/> Saddleback <input type="checkbox"/> Paramedic <input type="checkbox"/> Pre-Designated Physician: _____ <input type="checkbox"/> Employee treated in emergency room <input type="checkbox"/> Employee was transported by ambulance to: Hospital: _____ <input type="checkbox"/> Employee was hospitalized overnight
Date of Knowledge of Injury/Illness	Time of Knowledge: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	
Date claim form offered	Employee's description of injury <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Unknown	

Describe the injury/illness, including what, where, why, how the injury/illness occurred as it was reported to me:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What actions(s) have been, will be or could be taken to prevent reoccurrence?

\_\_\_\_\_

\_\_\_\_\_

Volunteer Authorization Form attached? <input type="checkbox"/> Yes <input type="checkbox"/> No		Volunteer Reports to: (if applicable)	
Print Supervisor Name	Did injury/illness cause absence from work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	
Supervisor Signature	Title	Date	Extension
Department Head Signature	Title	Date	Extension