CALIFORNIA STATE UNIVERSITY FULLERTON

For Risk Mgmt / EHS Only

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

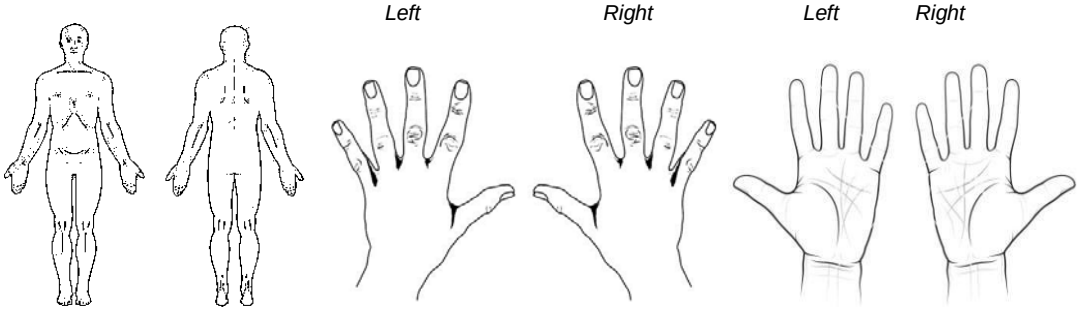
Division ☐AF ☐AA ☐SA ☐UA ☐IT ☐HR	Department	Supervisor Name	Supervisor Extension

Home Number or Cell	Sex ☐Male ☐Female	Date Hired	**Shift Time:** ☐A.M.☐ P.M ☐A.M.☐ P.M	Work Days ☐Su ☐M ☐T ☐W ☐Th ☐F ☐Sa

Job Title	☐Full-Time ☐Part-Time ☐Student Assistant ☐Volunteer	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



Name of Witness / Phone #

1.) _____

2.) _____

3.) _____

Date of Injury/Illness	**Time:** ☐A.M.☐P.M.	Location	Date Reported to Manager/ Supervisor	☐**Medical Treatment Declined** ☐**Claim Form received** (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:** ☐A.M.☐P.M.
Date of Knowledge of Injury/illness	**Time of Knowledge:** ☐A.M.☐P.M.
Date claim form offered	Employee's description of injury ☐Agree ☐Disagree ☐Unknown

Medical Treatment

☐ Medical Treatment Declined ☐ First Aid in Department
☐ Brea Urgent Care ☐ Sand Canyon ☐Saddleback
☐ Paramedic ☐Pre-Designated Physician:_____
☐ Employee treated in emergency room
☐ Employee was transported by ambulance to: Hospital:_____
☐ Employee was hospitalized overnight

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? ☐Yes ☐No	Volunteer Reports to: **(if applicable)**

Print Supervisor Name	Did injury/illness cause absence from work? ☐Yes ☐No ☐Don't Know	Has employee returned to work? ☐Yes ☐No ☐Don't Know

Supervisor Signature	Title	Date Extension

Department Head Signature	Title	Date Extension

Please return to Total Wellness (CP-700), a copy to EHS (T-1475) and retain a copy for the department