California State University Channel Islands

Supervisor's Injury or Illness Report

THE SUPERVISOR/MANAGER SHALL COMPLETE THIS FORM WITHIN 24 HOURS OF THE REPORTED INJURY OR ILLNESS AND SUBMIT THE FORM TO HUMAN RESOURCES.

☐ Documentation only, no treatment required by a physician (Complete sections 1, 3, 5, 8)

☐ Medical treatment and claim form required (Complete all sections)

Section 1

FULL NAME OF INJURED OR ILL EMPLOYEE

DATE OF INJURY OR ONSET OF ILLNESS

EMPLOYEE'S WORK PHONE

EMPLOYEE'S WORK SCHEDULE (EX. MON-FRI, 8:00 AM TO 4:00 PM)

EMPLOYEE'S HOME PHONE

EMPLOYMENT STATUS (EX. PERM, TEMP., SEASONAL, PART-TIME)

TIME WORK BEGAN

TIME OF INJURY/ILLNESS ONSET

Section 2

LAST DAY AT WORK DUE TO INJURY/ILLNESS

DATE RETURNED TO WORK

DATE EMPLOYEE WAS GIVEN CLAIM FORM

WAS EMPLOYEE PAID FULL WAGES FOR DATE OF INJURY? ☐ YES ☐ NO

Section 3

SPECIFIC LOCATION WHERE EVENT OR EXPOSURE OCCURRED (EX. SOLANO HALL, ROOM 1101)

IF LOCATION IS NOT ON EMPLOYER'S PREMISES, PLEASE PROVIDE ADDRESS

SPECIFIC INJURY/ILLNESS AND PART(S) OF BODY AFFECTED (EX. SPRAINED RIGHT ANKLE)

SPECIFY HOW THIS INJURY/ILLNESS OCCURRED (EX. EMPLOYEE MISSED LAST STEP ENTERING BASEMENT AND TWISTED ANKLE)

SPECIFY JOB OR TASK EMPLOYEE WAS PERFORMING WHEN INJURED OR BECAME ILL (EX. PREPARING TO PAINT STAIRWELL, EMPLOYEE WAS CARRYING SUPPLIES DOWN THE STAIRS)

SPECIFY ANY OBJECTS OR SUBSTANCES THAT MAY HAVE CONTRIBUTED TO OR CAUSED THE INJURY OR ILLNESS

Section 4

FACILITY NAME & LOCATION WHERE EMPLOYEE WAS SENT FOR MEDICAL TREATMENT

WAS EMPLOYEE HOSPITALIZED? ☐ YES ☐ NO

CHECK IF EMPLOYEE DECLINED TREATMENT ☐ YES, employee declined treatment

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Section 5

HAVE YOU TAKEN CORRECTIVE ACTIONS TO PREVENT SIMILAR INJURIES? ☐ YES ☐ NO

IF YES, PLEASE SPECIFY WHAT ACTIONS HAVE BEEN TAKEN:

IF NO, IS ASSISTANCE NEEDED TO TAKE CORRECTIVE ACTION? ☐ YES ☐ NO

PLEASE SPECIFY WHAT ASSISTANCE MAY BE NEEDED:

Section 6

IF INJURED EMPLOYEE IS MEDICALLY UNABLE TO PERFORM FULL DUTY, IS MODIFIED, TRANSITIONAL WORK AVAILABLE?

YES ☐ NO ☐ NOT SURE, MORE INFORMATION NEEDED ☐

HUMAN RESOURCES STAFF WILL CONTACT THE EMPLOYEE AND SUPERVISOR TO DISCUSS WORK RESTRICTIONS AND THE AVAILABILITY OF MODIFIED, TRANSITIONAL DUTY IF RECOMMENDED BY THE TREATING PHYSICIAN.

Section 7

ADDITIONAL INFORMATION

Section 8

REPORT COMPLETED BY (TYPE OR PRINT) DATE

SUPERVISOR'S SIGNATURE TITLE