CAL STATE LA UAS AUXILIARY SERVICES INC.
5151 State University Drive, GE 314, LA, CA 90032

SUPERVISOR'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

ALL INJURIES, EVEN MINOR ONES, MUST BE REPORTED. Complete this report within 24 hours of injury /illness. All questions are important and must be completed in detail.

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 TPA and the Department of Industrial Relations. Send ONE COPY to Human Resources Department (HRD), Attn: Workers' Compensation area, Golden Eagle Building, Room 314, (Mail Code 5621-01). HRD will prepare and submit the official report to the TPA. Retain a copy for your records. **FATAL** or **SERIOUS** injuries/illnesses must be reported **IMMEDIATELY** by telephone and on this form to Human Resources Department, which 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 the Human Resources Department is closed. If you have any questions, please contact Alejandra Ulloa at extension 3-2524.

PLEASE REPORT ALL INJURIES WITHIN ONE WORKING DAY TO YOUR EMPLOYER.
FILING THIS REPORT IS NOT AN ADMISSION OF LIABILITY

Part A – Employee's Personal Information

Name of Injured: _____ Social Security Number: _____

Address: _____

City: _____Zip Code: _____Date of Birth: _____

Classification: _____ Department: _____

Employee Status: Full-Time ____ Part-Time ____ Salary: _____ per month or _____ per hour

Date of Hire: _____ Total hours employee works: _____ daily _____ weekly

Part B – Injury/Illness

Date of injury: _____ Time of injury: _____ a.m./p.m. Date employee reported injury: _____

Witnesses (names and telephone numbers):

1. _____ 2. _____

3. _____ 4. _____

Where did the injury/illness occur?

_____

What was the employee doing when injured?

_____

How did the injury/illness occur?

_____

over ⇨

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Describe the nature of the injury/illness: _____

Describe the part(s) of the body injured: _____

Was another person responsible: No ___ Yes ___ (if yes, explain) _____

Part C – Medical Treatment

Where did the employee receive treatment?

____ CSULA Student Health Center
____ Concentra, 9350 Flair Drive, El Monte, CA 91731 (626) 407-0300
____ Concentra, 3430 S. Garfield Ave, Commerce, CA 90040 (323)722-8481(**Holidays, Weekend, Late Hours ONLY)**
____ Hospital: Name: _____ Address: _____
City_____ Zip Code _____ Phone Number: _____
____ Other: Name: _____

____ Declined Medical Care

Part D – Return to Work

Did the employee lose at least one (1) full day of work after the date of injury/illness? No ____ Yes ____

When did the employee return to work? _____ What type

of work did the employee return to? Regular ____ Modified _____

Part E – Accident Prevention

Describe the work place 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: _____Date: _____ Extension: _____

Employee's Signature: _____ Date:_____ Extension: _____

Forward this form to the Human Resources Department as soon as possible following the incident or near miss.

Note: If an employee receives medical treatment from a doctor or hospital, additional forms will need to be filled out and forwarded to the HR Dept. along with the incident report so a workers' compensation claimed can be filed.