Supervisor's Injury or Illness Report – Page 1

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, 7:00AM TO 4:00PM)

EMPLOYEE'S HOME PHONE

EMPLOYEE'S 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

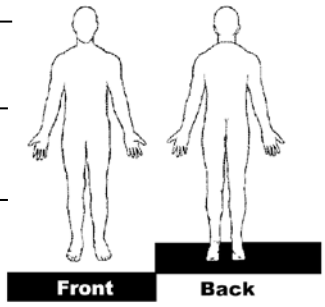
WAS EMPLOYEE PAID FULL WAGES FOR DATE OF INJURY? ☐ YES ☐ NO

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 (PLEASE ALSO CIRCLE ON DIAGRAM)



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 MEDICAL TREATMENT ☐ YES

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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 MODIFIED, TRANSITIONAL DUTY IF RECOMMENDED BY THE TREATING PHYSICIAN.

SECTION 7

INJURED EMPLOYEE COMMENTS:

_____

_____

_____ EMPLOYEE INITIALS

WITNESS NAMES: (PLEASE ATTACH STATEMENTS AS APPROPRIATE)

_____

_____

SECTION 8

_____	_____	_____	_____
REPORT COMPLETED BY	TITLE	SIGNATURE	DATE
_____	_____	_____	_____
SUPERVISOR'S NAME	TITLE	SIGNATURE	DATE

Print Form

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