CSUDH | HUMAN RESOURCES MANAGEMENT

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EMPLOYEE/VOLUNTEER REPORT OF WORK INCIDENT

PART I – EMPLOYEE INFORMATION

Employee Name *(Last, First M.I.)*	**Date of Birth**		**Home/Cell Phone**	
Home Address	**Unit/Apt.**	**City**	**State**	**Zip**
Email	**Department**		**Work Phone**	
Employment Status ☐Full-Time ☐Part-Time ☐Student Worker ☐Volunteer	**Hire Date**	**Job Title**		
Division ☐AF ☐AA ☐SA ☐UA ☐IT ☐PO	**Supervisor's Name**		**Supervisor's Phone**	
Work Schedule ____Hrs./Day____Days/Wk.	**Work Hours** _____☐AM ☐PM to_____☐AM ☐PM		**Work Days** ☐Sun ☐Mon ☐Tues ☐Wed ☐Thu ☐Fri ☐Sat	

PART II – INCIDENT INFORMATION

Date of Incident	**Time Incident Occurred** _____☐AM ☐PM	**Time Shift Began** _____☐AM ☐PM	**Location of Incident** *(If off campus, list location and address)*
Name of the Manager you reported the incident to:			**Date you reported the injury:**

Describe how the injury/illness occurred. Include the activity and tools, equipment and material used *(Example, "While working in the maintenance shop area I slipped on a screwdriver and fell injuring my low back and sustained a cut to right hand while catching my fall")*

List all of the body part(s) affected by the incident *(Example, "Low back pain and Cut to right hand")*

Was anyone else <u>involved</u> in the Incident? ☐Yes ☐No ☐Unknown	**If Yes, Who?**
Were there any <u>witnesses</u>? ☐Yes ☐ No ☐ Unknown	**If Yes, Who?**

Were you provided the "Employee's Claim For Workers' Compensation Benefits" Form (DWC1)? ☐Yes/Date Received _____☐ No

PART III – MEDICAL TREATMENT AND RETURN TO WORK

Choose your initial treatment location or Choose decline medical treatment (when medical care is not needed): (Select One):

☐Medical Treatment Declined ☐Student Health Center ☐Kaiser on the Job ☐Concentra ☐ ***Pre-desigated Physician(Form must be on file in HR)***

Did you return to work after initial treatment: ☐ Yes ☐ No Date Returned to Work:

What is your current work status?(Choose One): Regular ☐ Restricted/Modified Duties ☐

PART IV – ACCIDENT PREVENTION

What may prevent similar incidents/Injuries/Illnesses from occurring in the future? (Safety measures that may prevent re-occurrence)

Certification: *By signing this form the employee certifies that the information provided is true and correct to the best of the employee's knowledge.*

Employee Signature	**Date**