

Employee's Report of Work-Related Incident, Injury, or Illness

IF YOU BECOME INJURED ON THE JOB OR ILL BECAUSE OF YOUR WORK, YOU MUST NOTIFY YOUR SUPERVISOR IMMEDIATELY. YOUR SUPERVISOR OR WORKERS COMPENSATION STAFF WILL PROVIDE YOU WITH THE INCIDENT/INJURY/ILLNESS FORM BEFORE THE END OF YOUR WORK SHIFT. **INSTRUCTIONS-Documentation Only, No Treatment Required by Physician**

Employee - COMPLETE SECTIONS 1 and 2 AND SUBMIT TO WORKERS COMPENSATION STAFF IN ENTERPRISE RISK MANAGEMENT.
Supervisor- COMPLETE SECTIONS, 4, 5, 7 AND SUBMIT TO WORKERS COMPENSATION STAFF IN ENTERPRISE RISK MANAGEMENT.

INSTRUCTIONS-Medical Treatment Requested

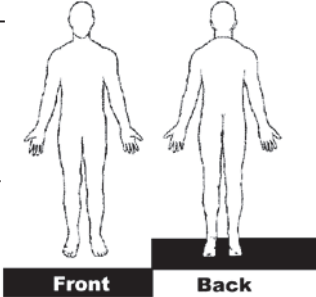
EMPLOYEE - COMPLETE SECTIONS 1 and 2 AND WC CLAIM FORM AND SUBMIT TO WORKERS COMPENSATION STAFF.

SUPERVISOR - COMPLETE SECTIONS 4, 5, 6, 7 AND SUBMIT TO WORKERS COMPENSATION STAFF.

SECTION 1-EMPLOYEE

| | | | | | |
|------------------------|--|---|----|--|----|
| _____ | | _____ | | _____ | |
| FULL NAME OF EMPLOYEE | | EMPLOYEE ID NUMBER | | DATE AND TIME OF INJURY OR ONSET OF ILLNESS | |
| _____ | | _____ | | _____ | |
| WORK PHONE NUMBER | | WORK SCHEDULE (EX: MON-FRI, 7:00AM TO 4:00PM) | | EMPLOYEE WORKING TITLE | |
| _____ | | _____ | | _____ | |
| HOME/CELL PHONE NUMBER | | E-MAIL ADDRESS | | DEPARTMENT | |
| _____ | | _____ | | _____ | |
| IS THIS A REPORT ONLY? | | YES | NO | ARE YOU REQUESTING MEDICAL TREATMENT BEYOND FIRST AID? | |
| | | | | YES | NO |

SECTION 2-EMPLOYEE

| | | |
|--|--|--|
| _____ | |  |
| SPECIFIC LOCATION WHERE EVENT OR EXPOSURE OCCURED (EX: HUMANITIES, ROOM 101) | | |
| IF LOCATION IS NOT ON SF STATE'S PREMISES, PLEASE PROVIDE ADDRESS | | |
| _____ | | |
| SPECIFIC INJURY/ILLNESS AND PART(S) OF BODY AFFECTED (PLEASE ALSO CIRCLE ON DIAGRAM) | | |
| _____ | | |
| SPECIFY HOW THIS INJURY/ILLNESS/INCIDENT OCCURRED (EX: MISSED LAST STEP ENTERING BASEMENT AND TWISTED ANKLE) | | |
| _____ | | |
| SPECIFY JOB OR TASK YOU WERE PERFORMING WHEN INJURED OR BECAME ILL (EX: PREPARING TO PAINT STAIRWELL) | | |
| _____ | | |
| SPECIFY ANY OBJECTS OR SUBSTANCES THAT MAY HAVE CONTRIBUTED TO OR CAUSED THE INJURY/ILLNESS/INCIDENT | | |
| _____ | | |
| WAS ANYONE WITH YOU WHEN THIS INJURY/ILLNESS OCCURED? IF YES, PLEASE PROVIDE THEIR NAME AND CONTACT INFO | | |
| _____ | | |
| EMPLOYEE COMMENTS | | |
| _____ | | |
| _____ | | _____ |
| EMPLOYEE SIGNATURE | | DATE |

Supervisor's/Chair's Incident, Injury, or Illness Report – Page 2

BEFORE END OF EMPLOYEE'S WORK SHIFT AND KNOWLEDGE OF INCIDENT/INJURY/ILLNESS, PLEASE COMPLETE YOUR SECTION OF THE FORM AND RETURN TO ENTERPRISE RISK MANAGEMENT.

SECTION 4

| | | |
|---|----------------------------|---|
| EMPLOYEE NAME | YES NO | DATE OF INITIAL TREATMENT |
| WAS FIRST AID GIVEN ON SITE? | | |
| WHAT TYPE OF MEDICAL TREATMENT DID EMPLOYEE RECEIVE? (CIRCLE ONE) | | |
| UNIVERSITY PROVIDER | PERSONAL PHYSICIAN | FIRST AID |
| EMERGENCY ROOM | DECLINED MEDICAL TREATMENT | |
| EMPLOYEE HOSPITALIZED OVERNIGHT? | YES NO | WAS EMPLOYEE INJURED ON THE JOB? YES NO |
| WAS EMPLOYEE PERFORMING REGULAR DUTIES AT TIME OF INJURY? | | YES NO |
| WAS SAFETY EQUIPMENT PROVIDED? | YES NO | IS EMPLOYEE CURRENTLY WORKING? YES NO |

SECTION 5

PLEASE DESCRIBE HOW INJURY/ILLNESS /INCIDENT OCCURRED

WAS AN UNSAFE CONDITION, CODE OF SAFE PRACTICE, EQUIPMENT/MACHINE PROBLEM, PERSONAL PROTECTIVE EQUIPMENT ATTRIBUTED TO THIS INJURY/ILLNESS? YES NO IF YES, PLEASE EXPLAIN (EX: NEEDED ERGO ASSESSMENT, HORSEPLAY)

WHAT COULD THE EMPLOYEE AND/OR MANAGEMENT HAVE DONE TO PREVENT THIS INJURY /ILLNESS? FOR EXAMPLE, EMPLOYEE COULD HAVE ASKED FOR HELP, MANAGEMENT COULD HAVE PROVIDED TRAINING?

CHAIR/MANAGER/SUPERVISOR COMMENTS

SECTION 6

IF INJURED EMPLOYEE IS RELEASED TO WORK WITH RESTRICTIONS, IS MODIFIED/ TRANSITIONAL WORK AVAILABLE? (CIRCLE ONE)

YES NO NOT SURE MORE INFORMATION ON RESTRICTIONS IS NEEDED

ENTERPRISE RISK MANAGEMENT STAFF WILL CONTACT THE SUPERVISOR TO DISCUSS WORK RESTRICTIONS AND MODIFIED , TRANSITIONAL WORK.

SECTION 7

| | |
|-------------------------------------|------|
| REPORT COMPLETED BY (PLEASE PRINT) | DATE |
| ADMINISTRATOR SIGNATURE (MPP LEVEL) | DATE |

You must fax the Employee and Supervisor Incident report along with the DWC-1 First Report of Injury to Enterprise Risk Management at (415) 338-0597.