SAN FRANCISCO STATE UNIVERSITY

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 _____

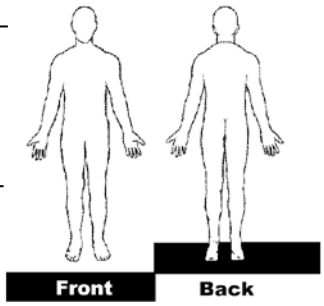
IS THIS A REPORT ONLY? YES NO ARE YOU REQUESTING MEDICAL TREATMENT BEYOND FIRST AID? YES NO

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 _____

Enterprise Risk Management, Administration 260; 415-338-2565; Fax 415-338-0597

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, WORKERS COMPENSATION IN ADMINSTRATION 260.

SECTION 4

EMPLOYEE NAME

WAS FIRST AID GIVEN ON SITE? YES NO

DATE OF INITIAL TREATMENT

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

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