

CSUSM CORPORATION

REPORT OF EMPLOYEE INJURY OR ILLNESS

ALL INJURIES, EVEN MINOR ONES, MUST BE REPORTED. Complete this report on day of injury or as soon as possible and send to CSUSM Corporation HR Office. All questions are important. Complete in detail.

PART I

To be filled out, by the injured employee.

				Department			
Name of injured (First) (MI) (Last)			Social Security No.		Married? Yes <input type="checkbox"/> No <input type="checkbox"/>		Male <input type="checkbox"/> Female <input type="checkbox"/>
Address of injured (Street) (City) (Zip)			Job Title		Hire Date		
Home phone number		Date of Birth		Full Time <input type="checkbox"/> Part Time <input type="checkbox"/>		Days S M T W Th F S Hours _ _ _ _ _ _ _ _	
Nature of Injury, Illness or Exposure and part of body affected							
Date of Injury		Hour a.m. p.m.	Names of Witnesses				
Describe where the Injury, Illness or Exposure occurred. (Address, City and County)							
HOW did the injury, illness, or exposure occur?							
Employee's Signature						Date	

PART II To be filled out by the injured employee's immediate supervisor or Project Director whose evaluation is vital to future accident prevention activities. Carefully evaluate any "act" or "condition" which caused the injury, illness, or exposure.

AN UNSAFE CONDITION EXISTED (Check all that apply)								
<input type="checkbox"/> Defective equipment (tools, materials)		<input type="checkbox"/> Slippery or uneven walking surfaces			<input type="checkbox"/> Other contributing factors (specify)			
<input type="checkbox"/> Safety Devices not provided		<input type="checkbox"/> Faulty layout of facilities						
<input type="checkbox"/> Poor working conditions (light, ventilation)		<input type="checkbox"/> Poor housekeeping						
AN UNSAFE ACT RESULTED FROM (Check all that apply)								
<input type="checkbox"/> Inadequate instruction		<input type="checkbox"/> Not using safety devices			<input type="checkbox"/> Improper work method			
<input type="checkbox"/> Disregarded rules		<input type="checkbox"/> Physical condition of injured does not meet task			<input type="checkbox"/> Improper body position			
<input type="checkbox"/> Haste: Carelessness		<input type="checkbox"/> Action of fellow worker			<input type="checkbox"/> Other contributing factors (specify)			
What have YOU done to prevent recurrence?								
Did injured go home? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, time _____ <input type="checkbox"/> am <input type="checkbox"/> pm		Was Employee unable to work on any day after injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, date last worked ____ / ____ / ____ Mo. Day Year		Date or estimated date of return to work ____ / ____ / ____ Mo. Day Year		<input type="checkbox"/> Regular work <input type="checkbox"/> Restricted work
Did Injured Report to a Physician <input type="checkbox"/> Yes <input type="checkbox"/> No		Name and Address of Physician:				Phone Number		
Did Injury Require Hospitalization <input type="checkbox"/> Yes <input type="checkbox"/> No		If hospitalized, name and address of hospital:						
Facts indicate this injury was caused by and happened during work <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know (Explain)								
Supervisor/Manager (PRINT)					Supervisor's Signature			
Date of Report		Phone No.		Health and Safety Officer				

Instructions: Complete and return this form to the CSUSM Corporation HR Office within 48 hours of the time of incident.