☐

☐

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: M-W-F, 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

IF LOCATION IS NOT ON EMPLOYER'S PREMISES, PLEASE PROVIDE ADDRESS

SPECIFIC INJURY/ILLNESS AND PART(S) OF BODY AFFECTED (PLEASE ALSO CIRCLE ON

SPECIFY HOW THIS INJURY/ILLNESS OCCURRED (EX: EMPLOYEE MISSED LAST STEP ENTERING BASEMENT

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 ILL

SECTION 4

FACILITY NAME & LOCATION WHERE EMPLOYEE WAS SENT FOR TREATMENT

WAS EMPLOYEE HOSPITALIZED? YES NO CHECK IF EMPLOYEE DECLINED MEDICAL TREATMENT

Supervisor's Injury or Illness Report – Page 2

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 A

YES NO NOT SURE, MORE INFORMATION NEEDED

HUMAN RESOURCES STAFF WILL CONTACT THE EMPLOYEE AND SUPERVISOR TO DISCUSS WORK RESTRIC MODIFIED, TRANSITIONAL DUTY IF RECOMMENDED BY THE TREATING PHYSICIAN.

SECTION 7

INJURED EMPLOYEE COMMENTS:

EMPLOYEE INITIALS

WITNESS NAMES: (PLEASE ATTACH STATEMENTS IF SEPARATE) OR