Clear

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

Before the end of employee's work shift and/or knowledge of Incident/Injury/Illness, please complete this form and return it to **Workers' Compensation in HUMAN RESOURCES, ADM 252**, or workerscomp@sfsu.edu, or Fax to HR at 415-338-0521.

SECTION 4

Employee Name _____

Was first aid given on site? Yes ◯ No ◯

Date of initial treatment _____

What type of Medical Treatment did employee receive? (Choose 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 the 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. (example: needed ergo assessment, horseplay, etc.)

_____

What could the employee and/or management have done to prevent this injury/illness? (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?

Yes ◯ No ◯ Not sure ◯ More information on restrictions is needed ◯

Workers' Comp staff will contact the supervisor when work restrictions are received, to discuss modified and/or transitional work.

SECTION 7

Report completed by (please print) _____ Working Title _____ Date _____

Administrative signature (MPP Level) _____ Working Title _____ Date _____

SAN FRANCISCO STATE UNIVERSITY

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Workers' Compensation
Human Resources, ADM 252
Email: workerscomp@sfsu.edu
Fax: 415-338-0521