California State University
MONTEREY BAY
Human Resources (831) 582-3389
100 Campus Center, Tide Hall Seaside, CA 93955-8001

CSUMB SUPERVISOR'S REPORT OF INCIDENT/ILLNESS/INJURY

UNDER NO CIRCUMSTANCES is the Injured/Ill Person to complete this form; only the Supervisor

Employee, Volunteer and Student Assistant Information

Name:_____ Work Ext: _____
Department: _____ Dept. Ext: _____
Supervisor: _____ Supervisor's Work Ext: _____
Supervisor Title: _____

Work Schedule (Please complete all information):
Days per week:_____Hrs. per week:_____ Work Hrs: ☐ 8:00-5:00 ☐ 7:30-4:30 Work Days:☐ M-F
☐ Other: _____ ☐ Other: _____

Incident/Illness/Injury Information

Date of incident/illness/injury: _____Time: _____ AM _____ PM
Your date of knowledge of incident/illness/injury: _____ Employee report submitted? ☐ Yes ☐ No
If employee/volunteer/student assistant died, date of death: _____
Was another person responsible for injury/incident? ☐ Yes ☐ No Were other workers injured? ☐ Yes ☐ No
Did incident/illness/injury occur at CSUMB? ☐ Yes ☐ No:_____
Location/Department where incident/illness/injury occurred: _____
Was injured/ill person acting in the line of duty? ☐ Yes ☐ No ☐ I don't know
Did incident result in compensation loss after the date of incident/illness/injury? ☐ Yes* ☐ No
*Last day worked prior to incident/illness/injury _____
Still off work? ☐ Yes ☐ No Date returned to work: _____ Date claim form provided: _____
Specific incident/illness and part(s) of body affected: (i.e., broken finger on right hand, tendonitis in left elbow, etc.)
_____
What was employee doing when he/she was injured or became ill? Attach separate sheet of paper if necessary. (i.e., loading boxes on truck; slipped and fell while descending a ladder and sprained his right ankle; lifting equipment, etc).
_____
What chemicals or equipment was employee using when this incident occurred? _____
What steps should be taken to prevent a similar Incident/Illness? _____

Verification - Please check one of the following:

☐ I verify that the illness/injury reported is work or volunteer-related.

☐ I am unable to determine if this illness/injury is caused by current employment/volunteer service. A Physician's report will be necessary to verify if the incident/illness/injury is related to employee's current employment at CSUMB or CSUMB-sponsored community service.

☐ The facts do not indicate that this claim of illness/injury is work or volunteer-related. Please investigate. Provide reasons why you believe this claim may not be work or volunteer-related in the space below:

Comments: _____

Please Note: **COMPLETING THIS FORM IS NOT AN ADMISSION OF LIABILITY**

6/2023

Supervisor completes the following:

Medical Information

Check appropriate box(s):

☐ **No Medical Treatment – Incident/Injury/Illness Report Only**

☐ **Medical Treatment Received at:**

☐ Doctors on Duty ☐ Campus Health Center ☐ Monterey Bay Urgent Care

☐ Natividad Medical Center Emergency ☐ Salinas Memorial Hospital Emergency Room ☐ CHOMP Emergency Room

Other - Please complete the following information:

Physician Name: _____ Address: _____

City/State/Zip: _____ Phone: _____ Date of Visit: _____

☐ **Hospitalized at:** _____

Facility Name: _____ Address: _____

Zipcode: _____ Date Hospitalized: _____ Phone: _____

Modified Work

If injured Employee/Volunteer is unable to perform full duties but may return to work on temporary limited duties, is modified work available or can an alternate work assignment be provided? Please check appropriate box:

☐ Temporary modified duties are available OR

☐ Alternate work assignment available (work other than regular assigned job/volunteer duties).

☐ No return-to-work plan developed: **Request assistance from University Personnel.**

If unable to provide modified duties or alternative work assignment, please list reasons:

_____

_____

Witnesses: (To be completed only if there were witnesses)

List Name(s) of Witnesses:

_____

Completed by:

Supervisor Signature: **Date:**

HEALTH & SAFETY REVIEW

Findings: _____

_____

_____

_____

Corrective Action: ☐ **Yes** ☐ **No** **Specifics:** _____

_____

_____

Corrective Action Verified as Completed: ☐ **Yes** ☐ **No**

Please return this immediately to Human Resources, Tide Hall, Bldg 23; leaves@CSUMB.EDU, 831-582-3539 / FAX 831-582-3572

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