SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS

*FORM MUST BE COMPLETED AND RETURNED TO HUMAN RESOURCES **WITHIN 24 HOURS** OF SUPERVISOR'S NOTICE*
UNDER NO CIRCUMSTANCES IS THE INJURED EMPLOYEE TO COMPLETE THIS FORM

EMPLOYEE INFORMATION

Name:
Home Telephone:
Address:
Sex: Male ☐ Female ☐
City/State/Zip:
Supervisor: Ext:
Department:
Dept. Head: Ext:

WORK SCHEDULE

Employee Usually Works: No. Days per week: _____ No. Hours per week: _____ No. Hours per day: _____

Work Schedule: _____ ☐ am ☐pm to: _____ ☐ am ☐pm Shift Work: ☐ Yes ☐ No

INJURY/ILLNESS INFORMATION

Date of Injury: _____
Time of Injury: _____ ☐ am ☐pm
Your date of knowledge: _____
Date claim form given to employee: _____

Witnesses? ☐ No ☐ *Yes **– Complete "A" below**
If employee died, date of death: _____
Was another person responsible? ☐ No ☐ Yes
Were other worker's injured? ☐ No ☐ Yes

Specific injury/illness and part(s) of body affected: (i.e., broken middle finger on **Right** hand, laceration on **Left** elbow, etc)-

What was employee doing when the event occurred? (i.e., loading boxes on truck, cleaning classroom, slicing meat, digging a trench, etc)

What chemicals, equipment, etc., was employee using when event occurred? (i.e., forklift, bleach, electric meat slicer, shovel/backhoe, etc)

Did injury/illness occur on employer's premises?
☐ Yes ☐ No

Location/Department where injury/illness occurred:

LOST TIME

Lost time? ☐ No ☐ Yes* - ***Dr. note required***
*Date last worked: _____

Still off work? ☐ Yes ☐ No* - ***Medical release required***
*Date Returned to work: _____

MEDICAL INFORMATION

CHECK APPROPRIATE BOX(S):
☐ **No Medical Treatment Sought by Employee** **Was employee treated in an emergency room?** ☐ Yes ☐ No
Medical treatment at: ☐ CMA STUDENT HEALTH CENTER ☐ KAISER OCCUPATIONAL HEALTH CLINIC ☐ MEDICAL DEPT – TSGB ☐ *OTHER
Please complete the following:
*Physician/Facility Name: *Address:
*City/State/Zip: *Phone:
If hospitalized, please complete: **Was employee hospitalized overnight as an in-patient?** ☐ Yes ☐ No
Facility Name: Address:
City/State/Zip: Phone:

A. WITNESSES - List name(s) of witnesses:

B. VERIFICATION – Please check one of the following:

☐ I verify that the injury/illness of this claim is work related
☐ I am unable to determine if this injury is caused by current employment. A physician's report will be necessary to verify if injury/illness is related to employee's current employment at Cal Maritime
☐ The facts do not indicate that this claim of injury is work-related. Please investigate. Please use back of this form to provide reasons to support why you believe this claim may not be work-related.

Completed by: (Print/Type Name, Title, Phone No.) Signature ____________ Date ____________