CAL MARITIME

200 Maritime Academy Drive
Vallejo, CA 94590

EMPLOYEE'S REPORT OF WORK-RELATED INJURY/ILLNESS

Employee must promptly report injury/illness to supervisor and complete form within 24 hours of incident

Employee's Name:	Date of Birth:	Sex:
Job Classification or Working Title:		
Work Telephone:	Home Telephone:	
Department:	Supervisor's Name:	
Date and Time of Accident/Injury or Onset of Illness:		
Time Employee Began Work:	Last Day Worked (Day of Week & Month/Day):	
Accident Reported to:	Date & Time Accident Reported:	
Name(s) and Addresses of Witness(es):		
Task being performed when accident/injury/illness occurred:		
Describe how the accident/injury/illness occurred:		
Part(s) of the body injured/affected:		
Describe your injury/illness in detail:		
Before this accident, did you ever suffer from any injury or disease? ☐ yes ☐ no If yes, give details:		
Date & Times you sought medical attention:		
Name & address of doctor and/or hospital:		
Have you returned to work? ☐ yes ☐ no If yes, give date:		
What action can be taken, if any, to prevent this type of injury/illness/accident?		

☐ I do ☐ I do not want to file for Workers' Compensation Benefits or seek medical treatment at this time.

Employee's Signature _____ Date _____

Any person who makes or causes to be made any knowingly false or fraudulent statement or representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Send completed form to Human Resources.

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