CSUDH | HUMAN RESOURCES MANAGEMENT

1000 East Victoria Street, WH 340 PHONE: (310) 243-3771
Carson, California 90747 FAX: (310) 928-7256

SUPERVISOR'S REPORT OF WORK INCIDENT & EHS INVESTIGATION REPORT

PART I – EMPLOYEE INFORMATION

Employee Name *(Last, First M.I.)*:	**Employee ID:**	**Home/Cell Phone:**
Job Title:	**Department:**	**Supervisor's Name:**
Employment Status: ☐ Full-Time ☐ Part-Time ☐ Volunteer ☐ Student Worker ☐ Temporary	**Work Schedule:** ____Hrs/Day____Days/Wk	**Time Shift Began:** _____☐ AM ☐ PM

PART II – INCIDENT INFORMATION

Date Incident Occurred:	**Time of Incident:** _____☐ AM ☐ PM	**Date Reported to Supervisor:**	**Date Reported to Human Resources:**

Describe the specific injury/illness and part(s) of body affected (e.g., left leg, right wrist, etc.):

Location where injury/illness occurred (In or near what building) (If off campus, list location and address):

Equipment, Materials and Chemicals the Employee was using when event or exposure occurred (e.g. Acetylene, welding torch, mower, scaffold, cart, etc.)

Describe the specific activity the employee was performing when the event or exposure occurred (e.g. walking, climbing ladder, keyboarding, etc.)?

How Injury/Illness Occurred. Described sequence of events. Specify the object or exposure which directly produced the injury/ illness, (e.g. Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand).

Were Other CSUDH ☐Employees or ☐Students Injured/Involved? ☐ Yes ☐ No ☐ Unknown	**If Yes, Who?**
Were There Any <u>Witnesses</u>? ☐ Yes ☐ No ☐ Unknown	**If Yes, Who?**

The injured employee provided you with a copy of the "Employee's Claim for Workers' Compensation Benefits" Form (DWC 1)?
☐ Yes ☐ No. **If Yes, what date did they provide the DWC-1 to you**? : _____

Do you have any question regarding this incident that you would like to discuss in detail? ☐ **Yes** ☐ **No**

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PART III – MEDICAL TREATMENT AND RETURN TO WORK

Where Did the Employee Receive Medical Treatment? Please Check <u>One</u>.

☐Medical Treatment Declined ☐Student Health Center ☐Kaiser on the Job ☐Concentra ☐ Treatment with personal physician

Physician Name_____Phone# _____

Did Injury/Illness Result in Missed Time from Work? ☐ Yes ☐ No	**If Yes, Give Last Date Worked:**	
Has Employee Returned to Work? ☐ Yes ☐ No	Date Returned:	☐ Regular Duties ☐ Restricted/Modified Duties

PART IV – ACCIDENT PREVENTION

What was the direct cause of the incident? (identify equipment/tools, substance, behavior and/or activity involved)

What may have prevented the incident (Explain safety measures that would have prevented the injury?)

If you believe nothing could have prevented the incident, please explain why.

What steps are you taking to reduce the likelihood of this type of incident recurring?

Certification: *By signing this form the Supervisor certifies that the information provided is true and correct to the best of the Supervisor's knowledge.*

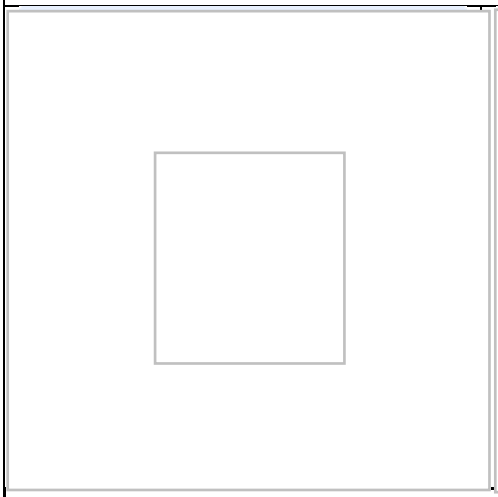
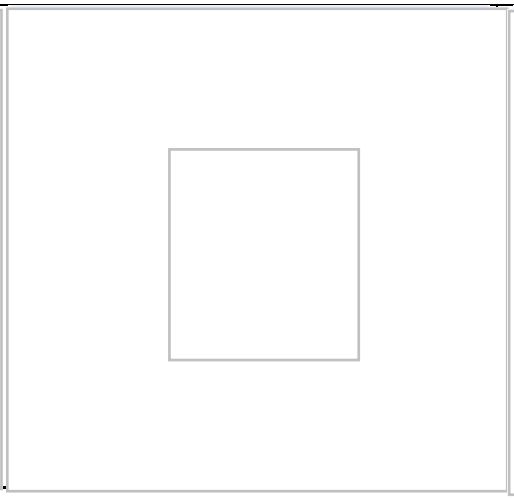
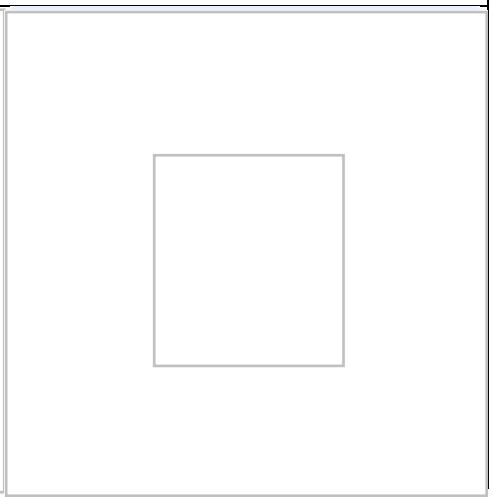
Supervisor Print and Signature:		**Date:**
Title:	**Email:**	**Extension:**

PART V – EHS investigation

Incident findings (review with supervisor and injured worker)

Corrective actions recommended

Actions implemented (30 day follow-up)

Investigator name and signature		**Date:**
Title:	**Email:**	**Extension:**