CLAREMONT UNIVERSITY CONSORTIUM

Workers' Compensation & Disability Office
Pendleton Business Building
101 S. Mills Ave.
Claremont, CA 91711
(909) 621-8847 Phone
(909) 607-9688 Fax

BENEFITS ADMINISTRATION

EMPLOYEE'S REPORT OF OCCUPATIONAL INJURY/ILLNESS
(To be submitted within two days of occurrence)

Name (print) Job Title:

1. College :	2. Department:	3. Department Phone:

4. Date of injury/illness:	5. Approximate time of injury/illness: ☐A.M. ☐ P.M.

6. Time work shift began:	7. Building where injury took place:	8. Floor/Room where injury took place:

9. Please describe fully how injury/illness occurred and indicate what you were doing at the time:

____

____

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10. Please describe the injury/illness:

11. Body part(s) affected: 12. ☐ Left ☐ Right

13.TYPE OF ACCIDENT (check all that apply)

☐ Animal/Insect Bite	☐ Collision (cart/vehicle)	☐ Foreign Body in Eye
☐ Contact With Hot Object	☐ Electrical Contact	☐ Fall (different/same level, liquid/grease spill)
☐ Material Handling	☐ Repetitive Motion	☐ Contusion (bruise)
☐ Strain	☐ Contact With Chemical	☐ Laceration/Puncture

☐ Other:____

14. Were there any witnesses to your injury/illness? ☐ No ☐ Yes	15. If "Yes", name of person(s):
16. Have you received medical care for this condition? ☐ No ☐ Yes	17. Do you wish to receive medical treatment?

18. If you have received medical treatment for this condition, please provide the following information:

Date Seen:__________________ Name of Doctor:__________________________ Address of Doctor:______________________________

19. Have you had a similar condition before? ☐ No ☐ Yes	20. If so, when?

21. In your opinion, what can be done to prevent such an accident from happening again?

____

____

I HAVE READ THIS STAEMENT AND IT IS TRUE TO THE BEST OF MY KNOWLEDGE.

Employee Signature____________________________________ Date________________________

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BENEFITS ADMINISTRATION

SUPERVISOR'S REPORT OF OCCUPATIONAL INJURY/ILLNESS
(To be submitted within two days of occurrence)

1. Employee's Name (print):

2. Job Title:

3. Date of injury/illness:

4. Date reported:

5. Time injury/illness reported: ☐ A.M. ☐ P.M.

6. Location of injury/illness:

7. Is the employee be paid full wages for the date of injury/illness: ☐ No ☐ Yes

8. Was the employee doing something other than his/her required duty at the time of injury? ☐ No ☐ Yes

9. If "Yes", please describe what, why, and directed by whom:

10. Please describe in detail what the employee was doing, how it was being done and tools, people or machines involved. If possible, give detail of weights, temperatures, chemicals, etc.:

11. Do you question the validity of this claim? ☐ No ☐ Yes

12. If "Yes" , give reason (witnesses, prior discussions, personal issues):

13. WHAT CAUSED THE INJURY/ILLNESS TO OCCUR? (check all that apply:

☐ Improper or defective equipment
☐ Inadequate safeguards, unsafe job design
☐ Lack of personal protective equipment
☐ Location (poor layout or lighting)
☐ Housekeeping, clutter, spillage, breakage
☐ Poor ergonomics in workstation design
☐ Lack of skill, training or experience
☐ Material handling
☐ Adequate skill but failure to execute & follow direction
☐ Other:______________________________

14. What can be done to prevent such an accident from happening again?

15. Who will assume responsibility to ensure the above is completed?

16. When will this be completed?

17. Supervisor completing this form:

18. Telephone Extension:

19. Department and Title:

20. Today's Date: