WORKERS' COMPENSATION AND DISABILITY ADMINISTRATION

Employee's Report

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* ☐AM ☐PM

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. *(describe below)*

10. Please describe the injury/illness *(describe below)*

11. Body part(s) affected 12. ☐left ☐right

13. Type of Accident *(check all that apply)*

- ☐ Animal/Insect Bite
- ☐ Electrical Contact
- ☐ Contusion (bruise)
- ☐ Laceration/Puncture
- ☐ Collision (car/vehicle)
- ☐ Fall (different/same level)
- ☐ Fall (liquid/grease spill)
- ☐ Other *(describe below)*
- ☐ Foreign Body in Eye
- ☐ Material Handling
- ☐ Strain
- ☐ Contact with Hot Object
- ☐ Repetitive Motion
- ☐ Contact with Chemical

14. Were there any witnesses to your injury/illness? ☐ Yes ☐ No

15. If "Yes," name of person(s)

16. Have you received medical care for this condition? ☐ Yes ☐ No

17. Do you wish to receive medical treatment? ☐ Yes ☐ No

18. If you have received medical treatment for this condition, please provide the following information: Date Seen | Doctor's Name and Address

19. Have you had a similar condition before? ☐Yes ☐No

20. If so, when?

21. In your opinion, what can be done to prevent such an accident from happening again? *(describe below)*

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

Signature Date

Serving: Pomona College 1887 • Claremont Graduate University 1925 • Scripps College 1926 • Claremont McKenna College 1946 • Harvey Mudd College 1955 • Pitzer College 1963 • Keck Graduate Institute 1997

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