Employee's Report of Work-Related Incident, Injury, or Illness

IF YOU BECOME INJURED ON THE JOB OR ILL BECAUSE OF YOUR WORK, YOU MUST NOTIFY YOUR SUPERVISOR IMMEDIATELY. YOUR SUPERVISOR OR EHS WILL PROVIDE YOU WITH THE INCIDENT/INJURY/IllNESS FORM BEFORE THE END OF YOUR WORK SHIFT.

INSTRUCTIONS - Documentation Only, No Treatment Required by Physician

Employee - COMPLETE SECTIONS 1 and 2 AND SUBMIT TO EHS.

Supervisor - COMPLETE SECTIONS 4, 5, 7 AND SUBMIT TO EHS.

INSTRUCTIONS - Medical Treatment Requested

EMPLOYEE - COMPLETE SECTIONS 1 and 2 AND WC CLAIM FORM AND SUBMIT TO EHS.

SUPERVISOR - COMPLETE SECTIONS 4, 5, 6, 7 AND SUBMIT TO EHS.

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SECTION 1 - EMPLOYEE

<table>
<thead>
<tr>
<th>FULL NAME OF EMPLOYEE</th>
<th>EMPLOYEE ID NUMBER</th>
<th>DATE AND TIME OF INJURY OR ONSET OF ILLNESS</th>
</tr>
</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>WORK PHONE NUMBER</th>
<th>WORK SCHEDULE (EX: MON-FRI, 7:00AM TO 4:00PM)</th>
<th>EMPLOYEE WORKING TITLE</th>
</tr>
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<tbody>
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<table>
<thead>
<tr>
<th>HOME/CELL PHONE NUMBER</th>
<th>E-MAIL ADDRESS</th>
<th>DEPARTMENT</th>
</tr>
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</table>

IS THIS A REPORT ONLY? YES NO ARE YOU REQUESTING MEDICAL TREATMENT BEYOND FIRST AID? YES NO

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SECTION 2 - EMPLOYEE

SPECIFIC LOCATION WHERE EVENT OR EXPOSURE OCCURRED (EX: HUMANITIES, ROOM 101)

IF LOCATION IS NOT ON SF STATE'S PREMISES, PLEASE PROVIDE ADDRESS

SPECIFIC INJURY/IllNESS AND PART(S) OF BODY AFFECTED (PLEASE ALSO CIRCLE ON DIAGRAM)

SPECIFY HOW THIS INJURY/IllNESS/INCIDENT OCCURRED (EX: MISSED LAST STEP ENTERING BASEMENT AND TWISTED ANKLE)

SPECIFY JOB OR TASK YOU WERE PERFORMING WHEN INJURED OR BECAME ILL (EX: PREPARING TO PAINT STAIRWELL)

SPECIFY ANY OBJECTS OR SUBSTANCES THAT MAY HAVE CONTRIBUTED TO OR CAUSED THE INJURY/IllNESS/INCIDENT

WAS ANYONE WITH YOU WHEN THIS INJURY/IllNESS OCCURRED? IF YES, PLEASE PROVIDE THEIR NAME AND CONTACT INFO

EMPLOYEE COMMENTS

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EMPLOYEE SIGNATURE DATE
Supervisor's/Chair's Incident, Injury, or Illness Report – Page 2

Before end of employee's work shift and knowledge of incident/injury/illness please complete your section of the form and return to environment, health, and safety (EHS) in administration 260.

<table>
<thead>
<tr>
<th>Employee Name</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was first aid given on site?</td>
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</tbody>
</table>

What type of medical treatment did employee receive? (circle one)
- University provider
- Personal physician
- First aid
- Emergency room
- Declined medical treatment

Employee hospitalized overnight? Yes No
Was employee injured on the job? Yes No

Was employee performing regular duties at time of injury? Yes No

Was safety equipment provided? Yes No
Is employee currently working? Yes No

Please describe how injury/illness/incident occurred

Was an unsafe condition, code of safe practice, equipment/machine problem, personal protective equipment attributed to this injury/illness? Yes No
If yes, please explain (ex: needed ergo assessment, horseplay)

What could the employee and/or management have done to prevent this injury/illness? For example, employee could have asked for help, management could have provided training?

Chair/Manager/supervisor comments

If injured employee is released to work with restrictions, is modified/transitional work available? (Circle one)
- Yes
- No
- Not sure
- More information on restrictions is needed

Environment, health and safety (EHS) staff will contact the supervisor to discuss work restrictions and modified, transitional work.

Report completed by (please print)

Date

Administrator signature (MPP level)

Date

Make safety happen

Environment, health, & Safety

Rev 06/2017

Enviroment, Health and Safety ADM 260 Phone 415-338-2565, Fax 415-338-2498