CSUSM CORPORATION

REPORT OF EMPLOYEE INJURY OR ILLNESS

ALL INJURIES, EVEN MINOR ONES, MUST BE REPORTED. Complete this report on day of injury or as soon as possible and send to CSUSM Corporation HR Office. All questions are important. Complete in detail.

PART I

To be filled out, by the injured employee.

Department			
Name of injured (First) (MI) (Last)	Social Security No.	Married? Yes ☐ No ☐	Male ☐ Female ☐
Address of injured (Street) (City) (Zip)		Job Title	Hire Date
Home phone number	Date of Birth	Full Time ☐ Part Time ☐	Days S M T W Th F S Hours _ _ _ _ _ _ _
Nature of Injury, Illness or Exposure and part of body affected			
Date of Injury	Hour a.m. ◯ p.m. ◯	Names of Witnesses	
Describe where the Injury, Illness or Exposure occurred. (Address, City and County)			
HOW did the injury, illness, or exposure occur?			
Employee's Signature		Date	

PART II To be filled out by the injured employee's immediate supervisor or Project Director whose evaluation is vital to future accident prevention activities. Carefully evaluate any "act" or "condition" which caused the injury, illness, or exposure.

AN UNSAFE CONDITION EXISTED (Check all that apply)

☐ Defective equipment (tools, materials)
☐ Safety Devices not provided
☐ Poor working conditions (light, ventilation)
☐ Slippery or uneven walking surfaces
☐ Faulty layout of facilities
☐ Poor housekeeping
☐ Other contributing factors (specify)

AN UNSAFE ACT RESULTED FROM (Check all that apply)

☐ Inadequate instruction
☐ Disregarded rules
☐ Haste: Carelessness
☐ Not using safety devices
☐ Physical condition of injured does not meet task
☐ Action of fellow worker
☐ Improper work method
☐ Improper body position
☐ Other contributing factors (specify)

What have YOU done to prevent recurrence?

Did injured go home? ☐ Yes ☐ No If yes, time _____ ☐ am ☐ pm	Was Employee unable to work on any day after injury? ☐ Yes ☐ No	If yes, date last worked ___/___/___ Mo. Day Year	Date or estimated date of return to work ___/___/___ Mo. Day Year ☐ Regular work ☐ Restricted work
Did Injured Report to a Physician ☐ Yes ☐ No	Name and Address of Physician:		Phone Number
Did Injury Require Hospitalization ☐ Yes ☐ No	If hospitalized, name and address of hospital:		
Facts indicate this injury was caused by and happened during work ☐ Yes ☐ No ☐ Don't Know (Explain)			
Supervisor/Manager (PRINT)		Supervisor's Signature	
Date of Report	Phone No.	Health and Safety Officer	

Instructions: Complete and return this form to the CSUSM Corporation HR Office within 48 hours of the time of incident.