California State University SAN MARCOS

WORKERS' COMPENSATION CLAIM
EMPLOYEE INTAKE SHEET

The Office of Human Resources · 333 S. Twin Oaks Valley Road · San Marcos, CA 92096-0001 · (760)750-4416 · Secure Fax (833)536-1793 · hrbenefits@csusm.edu

INJURED WORKER'S INFORMATION AND INJURY DETAILS – TO BE COMPLETED BY INJURED WORKER					
Name		EMPL ID		DOB	
Work Phone		Home or Cell Phone			
Department		Division			
Working Title		Regular Work Location			
INJURY DETAILS					
Date of Injury		Time of Injury			
Time shift began on date of injury					
Location where the injury occurred? (ex: Craven, 1st floor near elevator)					
Describe the affected body part(s) (ex: right arm, left foot)					
How did the injury occur? (ex: slipped on wet floor)					
Additional Information					
SUPERVISOR'S INFORMATION					
Supervisor's Name (MPP status)					
Supervisor's Phone		Supervisor's Email			
Date Supervisor was notified of this injury					

Please return your completed form to the Workers' Compensation Coordinator (WCC) in OHR within 24 hours of the reported injury (Email to hrbenefits@csusm.edu). Thank you.

FOR WCC USE ONLY		
Date of Hire		
Monthly Gross Salary (Used to calculate IDL/TD as applicable)		
Employee category Confidential (C99), MPP (M80), Excluded (E99) or union code		
Report(s) Available?	Police Report	☐ Yes ☐ No
	Initial Incident/Accident Report	☐ Yes ☐ No
Claim Number		