

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<br>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?<br>(ex: Craven, 1 <sup>st</sup> floor near elevator) |                |                       |     |  |
| Describe the affected body part(s) (ex: right arm, left foot)                            |                | l,                    |     |  |
| 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 <u>hrbenefits@csusm.edu</u>). 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                                  |                                  |            |  |  |