

Workers' Compensation Claim – Intake Sheet

Cal State San Marcos
Office of Human Resources

EMPLOYEE MUST PROVIDE INJURED WORKER & SUPERVISOR INFORMATION

INJURED WORKER'S INFORMATION			
Name			
Date of Injury		Date of Birth	
Work Phone		Home Phone	
Department		Division	
Working Title/Occupation		Work Location	
Describe the Affected Body Part(s) (i.e. right arm, left foot)			
Location Where Injury Occurred? (i.e. Craven 1 st floor lobby near elevator)			
How Did Injury Occur? (i.e. Slipped on wet floor)			
Additional Notes			
SUPERVISOR'S INFORMATION			
Supervisor's Name (MPP Status)			
Supervisor's Phone			
Date Employee Notified Supervisor			

FOR WCC USE ONLY			
Date of Hire			
Monthly Gross Salary (Used to Calculate IDL/TD as Applicable)			
Union Name or Unit #, Confidential (C99), MPP (M80) or Not Applicable (N/A)			
Report(s) Available?	Police Report	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Initial Incident/Accident Report	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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.