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Workers' Compensation Claim – Intake Sheet

Cal State San Marcos

Safety, Risk & Sustainability

*****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 1st 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	☐ Yes ☐ No
	Initial Incident/Accident Report	☐ Yes ☐ No

Please return your completed form to the Workers' Compensation Coordinator (WCC) in SR&S within 24 hours of the reported injury (Deliver to Craven 4th Floor, Ste.4700 or Fax to 760/750-3396). Thank you.