California State University
SAN MARCOS

CSUSM EMPLOYEE ACCIDENT/INCIDENT FORM

*To be completed **immediately** by management at time of incident or knowledge of incident.*

PERSONAL INFORMATION OF INJURED

Name of Injured			
Relationship to CSUSM: ☐ Staff/Faculty ☐ Student Assistant ☐ Professional Program ☐ Volunteer			
Student ID or Employee ID			
Address	Street City State Zip		
Phone		Cell Phone	
Email Address			

DETAILS OF INJURY/ILLNESS

Date of Injury/onset of Illness:	Time injury/illness occurred: ☐ A.M. ☐ P.M.	Were other workers injured or became ill in this incident? Yes No
Specific injury/illness and body part affected		
Did the incident occur on CSUSM (San Marcos campus) premises: Yes No If yes, provide department/location: If no, provide location where incident occurred:		
Equipment, materials and/or chemicals in use when incident/exposure occurred:		
Describe how the injury/illness occurred, include property damage if applicable:		
Probable cause/causes:		
Witnesses, include name and contact information: Statement Rec'd ______________________________ ______________________________		

ACTION TAKEN AT TIME OF INCIDENT

Was medical assistance provided at the time the injury occurred? Yes No
If yes, provide a brief description and who provided:

Hospitalized: Yes No
If yes, where: _______________ Time Admitted: __________ A.M. P.M.
Transported by: ☐ UPD ☐ Ambulance/Paramedics ☐ MPP ☐ Self ☐ Other:

COMPLETE THE FOLLOWING IF THE INJURED INDIVIDUAL IS A CSUSM EMPLOYEE

Employee's Title/Occupation			
Department		Supervisor	
Time employee began work on day of injury/illness:		Scheduled hours on day of incident:	
Date of knowledge or notice of injury/illness:	Did the employee notify you of the need to seek medical services? Yes No		
Unable to work for at least one full day after date of injury? Yes No	Date last worked (mm/dd/yy):	Date Returned to work (mm/dd/yy):	If still off work, check this box:

Reported by: ☐ UPD ☐ Supervisor/Manager ☐ OHR ☐ Other: ______________

Reported by Contact: ______________ ______________ ______________
Name Phone Email

Safe Practice violation or corrective action? ☐ Yes ☐ No If yes, Form 5B must be completed within 15 days.

Initial Investigation Performed by: ________________________________
Print Name/Title Signature Date

Attention: This form contains information related to an individual's health and must be used in a manner that protects the confidentiality to the extent possible while the information is being used for occupational safety and health purposes.