California State University, Fresno

Print Form

SUPERVISOR'S REPORT OF WORK INJURY / ILLNESS

ALL INJURIES | ILNESSES MUST BE REPORTED. Complete this report IMMEDIATELY UPON NOTIFICATION of an on-the-job injury/illness.. ALL SERIOUS INJURIES / ILNESSES MUST BE REPORTED IMMEDIATELY to EHS at (559) 278-7422.

Employee Name # | Social Security # | Phone #:

Address | City | State CA | Zip

Department | Job Position/Title | ◯ Full ◯ Part Time

Supervisor's Name | Phone # | Mail Stop

1. Date and time of injury/illness: | Location

2. Date and time of injury/illness reported to you:

3. Did employee receive the Employee's claim for Worker's Compensation Benefits form (DWC form 1) ◯ Yes ◯ No

Date provided: Contact Tracey Garza at (559) 278-2125 to send out the DWC1 form

4. Name (s) of witness (es):

5. Injury / illness resulted in: First aid given? ◯ Yes ◯ No Medical treatment required? ◯ Yes ◯ No

If yes, please provide name of physician and/or facility where treated

6. Did injury /illness result in disability beyond day of accident? ◯ Yes ◯ No If yes, give date last worked

7. Describe how the injury/illness occurred

8. Nature of injury/illness/part of body injured

9. What actions, events or conditions contributed most directly to this accident?

10. What could be done to prevent injuries/illness of this type?

SIGNATURE OF SUPERVISOR

DATE

Distribute: Send original to Worker's Compensation Manager Tracey Garza M/S: JA41 Tel: (559) 278-2125
Please fax to Tracey Garza (559) 278-6995