

## SUPERVISOR'S REPORT OF WORK INCIDENT & EHS INVESTIGATION REPORT

PART I – EMPLOYEE INFORMATION			
Employee Name <i>(Last, First M.I.):</i>	Employee ID:	Home/Cell Phone:	
Job Title:	Department:	Supervisor's Name:	
<b>Employment Status:</b> <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Volunteer <input type="checkbox"/> Student Worker <input type="checkbox"/> Temporary	<b>Work Schedule:</b> ____Hrs/Day ____Days/Wk	<b>Time Shift Began:</b> _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	
PART II – INCIDENT INFORMATION			
Date Incident Occurred:	Time of Incident: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	Date Reported to Supervisor:	Date Reported to Human Resources:
Describe the specific injury/illness and part(s) of body affected (e.g., left leg, right wrist, etc.):			
Location where injury/illness occurred (In or near what building) (If off campus, list location and address):			
Equipment, Materials and Chemicals the Employee was using when event or exposure occurred (e.g. Acetylene, welding torch, mower, scaffold, cart, etc.)			
Describe the specific activity the employee was performing when the event or exposure occurred (e.g. walking, climbing ladder, keyboarding, etc.)?			
How Injury/Illness Occurred. Described sequence of events. Specify the object or exposure which directly produced the injury/illness, (e.g. Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand).			
Were Other CSUDH <input type="checkbox"/> Employees or <input type="checkbox"/> Students Injured/Involved? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		If Yes, Who?	
Were There Any <u>Witnesses</u> ? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		If Yes, Who?	
The injured employee provided you with a copy of the "Employee's Claim for Workers' Compensation Benefits" Form (DWC 1)? <input type="checkbox"/> Yes <input type="checkbox"/> No. If Yes, what date did they provide the DWC-1 to you? : _____			
Do you have any question regarding this incident that you would like to discuss in detail? <input type="checkbox"/> Yes <input type="checkbox"/> No			

**SUPERVISOR’S REPORT OF WORK INCIDENT**

**PART III – MEDICAL TREATMENT AND RETURN TO WORK**

**Where Did the Employee Receive Medical Treatment? Please Check One.**

Medical Treatment Declined  Student Health Center  Kaiser on the Job  Concentra  Treatment with personal physician

Physician Name \_\_\_\_\_ Phone# \_\_\_\_\_

**Did Injury/Illness Result in Missed Time from Work?**

Yes  No

**If Yes, Give Last Date Worked:**

Has Employee Returned to Work?

Yes  No

Date Returned:

Regular Duties  Restricted/Modified Duties

**PART IV – ACCIDENT PREVENTION**

**What was the direct cause of the incident? (identify equipment/tools, substance, behavior and/or activity involved)**

**What may have prevented the incident (Explain safety measures that would have prevented the injury?)**

**If you believe nothing could have prevented the incident, please explain why.**

**What steps are you taking to reduce the likelihood of this type of incident recurring?**

**Certification:** By signing this form the Supervisor certifies that the information provided is true and correct to the best of the Supervisor’s knowledge.

**Supervisor Print and Signature:**



**Date:**

**Title:**

**Email:**

**Extension:**

**PART V – EHS investigation**

**Incident findings (review with supervisor and injured worker)**

**Corrective actions recommended**

**Actions implemented (30 day follow-up)**

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**Investigator name and signature**



**Title:**

**Email:**

**Date:**

**Extension:**