San Francisco State University

Environmental Health and Safety
1600 Holloway Avenue, ADM 260
San Francisco, CA 94132
Tel: (415) 338-2565• FAX: (415) 338-2498

Work Related Report of Injury/Illness Form

If you become injured on the job or become ill because of your work, you must notify your supervisor immediately. Your supervisor will provide you with the Work Related Report Injury/Illness Form within 24-hours of their knowledge of your injury/illness.

EMPLOYEE SECTION

Please complete & sign employee section of form below and return it to your supervisor/manager

Employee Name (First Middle Last):		Employee ID Number and E-mail:
Street Address, City, State, Zip Code:		
Home/Cell Phone:	Work Phone:	Department:
Date of Birth:	Gender: M / F	Employee Working Title:
Employment Status:	Shift Days: M T W TH F S Su	Shift: FT/ PT
Time You Began Work:	Do you have an employer other than SFSU? If Yes, Employer Name:	
Date and Time of Injury/Illness:	Date and Time Reported to Supervisor:	Who did you first report the Injury to:
Injury/Illness Location: Building and/or Company name, address & phone number:		
Did the Injury/Illness occur on : □ SFSU premises □ Other Location (off campus)	Describe details of the site where injury/illness occurred (i.e. dark parking lot, unlit room):	
What were you doing just prior to the injury/illness (i.e. moving computers, loading laundry)?		
What is the specific body part injury or specific illness (i.e. tip of pinky finger, wrist, lower back)?		
What object/substance directly harmed you (i.e. ladder, cabinet, mouse)?	Was a third party responsible for the injury/illness? If yes, Name, Address & phone number needed:	
Did you pre-designate a physician **prior** to this injury? If **yes**, please indicate the name & phone number of the doctor/clinic:		
Was anyone with you when this injury/illness occurred? If yes, please provide their name and contact information.		
Any person who knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.		
Employee signature:	Date:	

CHAIR/MANAGER/SUPERVISOR SECTION

- **Prior to completing this section, please verify that the employee has completed all information in the employee section above.**
- **Within 24 hours of knowledge of injury/illness please complete your section of this form and fax to Victoria Ramos-Sponza, Workers' Compensation Manager, Environmental Health and Safety or drop-off original in ADM 260. Tel: 415-338-1545; Fax number: 415-338-2498.**

Employee Name:				
Was First Aid given on site?	What type of medical treatment was received?			
Date of initial treatment:	Has the employee previously expressed complaints about this body part to you?			
Was employee hospitalized overnight?	Did injury/illness result in fatality? If yes, what date:			
Type of treatment facility the employee visited (i.e. Student Health Center, Personal Physician, University Provider, Emergency Room):				
Name / Address / Phone Number of treatment facility:				Was injury/illness reported to Police?
Chair/Manager/Supervisor Name and Title:			Chair/Manager/Supervisor Phone Number:	
Was employee performing regular duties at time of injury?	Was employee injured while on the job?	Was employee paid in full for day of injury?	Is Employee Full Time or Part Time:	Please indicate the number of hours the employee works per day:
Last day employee worked:	First day of work missed:	Has employee returned to work?	Was Safety equipment provided?	
Please describe how injury/illness occurred:				
Was an unsafe condition, Code of Safe Practice, equipment/machine problem, personal protective equipment or element defective attributed to this injury/illness? If so, please explain (i.e. employee wasn't wearing goggles, needed ergonomic assessment, horseplay):				
What could have the employee done to prevent this injury/illness (i.e. worn proper equipment, asked for help)?				
What could management have done to prevent this injury/illness (i.e. provided ergonomic assessment, given training)?				
List root cause of injury/illness and was root cause addressed? If so, please explain (i.e. employee pushes self too hard to complete tasks, needs to take breaks, recognize limits):				
Comments:				
Administrator Signature (MPP level, please print)				Date: