UAS CAL STATE LA UNIVERSITY
AUXILIARY SERVICES INC.
5151 State University Drive, GE 314, LA, CA 90032

EMPLOYEE'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

ALL INJURIES, EVEN MINOR ONES, MUST BE REPORTED. Complete this report within 24 hours of injury or as soon as possible. All questions are important and must be completed in detail.

1. Notify your immediate supervisor as soon as possible of any injury/illness sustained during the course of your work with UAS
2. Obtain medical care from:
   a. Cal State L.A. Student Health Center; or
   b. Concentra (9350 Flair Drive, Ste. 102, El Monte, CA 91731) ; or
   c. Your personal physician (authorized only if you have submitted a Designation of Physician form to Human Resources Department before your date of injury)
3. Within one working day, complete and return to your immediate supervisor:
   a. Employee's Report of Occupational Injury/Illness
4. Continue with medical treatment as prescribed by the treating medical provider. After each medical visit, submit a copy of your medical status documents to:
   a. Your immediate supervisor, and UAS/HRD

Upon receipt of the appropriate forms, Human Resources Department will coordinate the claim processing with the insurance provider, the employing department, the medical provider and the employee. Should you require further assistance with this form, please contact USA/HRD at 3-2524 or 3-2530.

Part A - Personal Information

Name of Injured: _____ Social Security No.:_____
Last Middle First

Address of Injured: _____ City: _____ Zip Code: _____

Home Phone Number: _____ Date of Birth: _____ Salary: _____

Part B - Employment Status

Job Title: _____ Department: _____

Hire Date: _____ Employee Extension: _____

Name of Supervisor: _____ Supervisor's Extension: _____

Part C – Injury/Illness

Date of Injury: _____ Time: _____ a.m./p.m. Date you reported Injury:_____

Witnesses (Names and Telephone Numbers):
1. _____ 2. _____
3. _____ 4. _____

Over ⇨

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Where did the injury/illness occur: _____

_____

What were you doing when the injury/illness occurred: _____

_____

How did the injury/illness occur: _____

_____

Describe the nature of the injury/illness: _____

_____

Describe the part(s) of the body injured: _____

Was another person responsible: Yes ____ No ____ If yes, explain. _____

_____

Part D – Medical Treatment

Where did you receive treatment?

☐ CSULA Student Health Center (323) 343-3301
☐ Concentra, 9350 Flair Drive, El Monte, CA 91731 (626) 407-0300
☐ Concentra, 3430 S. Garfield Ave, Commerce, CA 90040 (323)722-8481(**Holidays, Weekend, Late Hours ONLY)**
☐ Hospital: Name: _____ Address: _____
☐ Other: Name: _____
☐ Declined Medical Care

Part E – Return to Work

Did you lose at least one (1) full day of work after the date of injury/illness: Yes ☐ No ☐

Did you return to work: Yes ☐ (returned to work on _____) No _____

What type of work did you return to: Regular _____ Modified _____

Part F – Accident Prevention

Describe the work place and conditions, which may have contributed to the injury/illness and safety devices present: _____

_____

What recommendations would you suggest which may correct the condition(s) and/or prevent future injuries/illnesses of the type: _____

_____

Employee's Signature _____ Date: _____