

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

California law requires an employer to report within five days every injury or occupational illness which: (1) results in time lost beyond the day of injury or (2) requires medical treatment other than first aid.

This report is required by our TPA and the Department of Industrial Relations. Send ONE COPY to Human Resources Department (HRD), Attn: Workers' Compensation area, Golden Eagle Building, Room 314, (Mail Code 5621-01). HRD will prepare and submit the official report to the TPA. Retain a copy for your records. **FATAL** or **SERIOUS** injuries/illnesses must be reported **IMMEDIATELY** by telephone and on this form to Human Resources Department, which will then report to the TPA and the Division of Industrial Safety as required by law. The Department of Public Safety is responsible for making these reports to the Division of Industrial Safety when the Human Resources Department is closed. If you have any questions, please contact Maria Nunez at extension 3-2524.

## PLEASE REPORT ALL INJURIES WITHIN ONE WORKING DAY TO YOUR EMPLOYER. FILING THIS REPORT IS NOT AN ADMISSION OF LIABILITY

Social Securit	y Number:	
Zip Code:	Date of Birth:	
Department:		
Salary:	per month or	per hour
employee works:	daily	weekly
_a.m./p.m. Date er	nployee reported injury:	
2		
4		
,		
	Zip Code: Department: Salary: employee works: a.m./p.m. Date er 2 4	Social Security Number: Zip Code:Date of Birth: Department:per month or employee works:daily employee works:daily daily daily daily daily daily daily daily daily daily daily daily daily daily  

## Part A – Employee's Personal Information



Describe the nature of the injury/illness:
Describe the part(s) of the body injured:
Was another person responsible: No Yes (if yes, explain)
Part C – Medical Treatment
Where did the employee receive treatment?
<ul> <li>CSULA Student Health Center</li> <li>Concentra, 9350 Flair Drive, El Monte, CA 91731 (626) 407-0300</li> <li>Concentra, 3430 S. Garfield Ave, Commerce, CA 90040 (323)722-8481(<u>Holidays, Weekend, Late Hours ONLY</u>)</li> <li>Hospital: Name: Address:</li> <li>City Zip Code Phone Number:</li> </ul>
City Zip Code Phone Number: Other: Name:
Declined Medical Care
Part D – Return to Work
Did the employee lose at least one (1) full day of work after the date of injury/illness? No Yes
When did the employee return to work? What type
of work did the employee return to? Regular Modified
Part E – 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 this type:
Supervisor's Signature:Date: Extension: