# California State University, Bakersfield

## Supervisor Report of Injury

Office of Human Resources
9001 Stockdale Highway Bakersfield, California 93311

Office: (559) 278-2125
Fax: (559) 278-6995

**To be completed by the injured worker's Supervisor. All injuries must be reported other than minor first aid. This form must be completed in full using all information available and returned to the Office of Human Resources immediately after the injury is known. Incomplete or illegible forms will be returned to the originating department.**

### Injured Worker Information

| **Name** | **Position Title** | **Department Name** | **Phone Number** |
|---|---|---|---|
| | | | |

**Work Schedule Days** *(check as needed)*

Mon – Fri or specify days:

Sun Mon Tues Weds Thurs Fri Sat

**Scheduled Hours on Date of Injury**

From am pm To am pm

**# of Hours Per Week**

**Has Injured Worker Returned to Work?**

Yes If Yes, Date Returned ________________

No If No, Last Date Worked ______________

| **Specific Location or Area Where Injury Occurred** | **Address/City** |
|---|---|
| | |

### Supervisor Information

| **Name** | **Title** | |
|---|---|---|
| **Date Injury Was Reported to Supervisor** | **Department Name** | **Phone Number** |
| | | |

### Medical Treatment

**Did Worker Require Medical Treatment?**

Yes No Unknown

**Name of Physician:**

**Specific Injury** *(if known)*:

**If Medical Treatment Required, How and Where was Treatment Provided?**

**Treated Self** (No Medical Treatment Sought) **Treated at CSUB Student Health Center**

**Treated at Other Location:**

**Medical Facility:** ____________________________________________

**Street Address:** ____________________________________________

**City:** _______________________________ **Phone:** ______________

**How Was Injured Worker Transported to Medical Facility?**

### Injury/Illness Information

| **Date of Injury** (mm/dd/yy) | **Time** am pm | **Witnesses** *(provide name & phone number)* |
|---|---|---|
| | | |

**Describe How Injury Occurred:**

**What Equipment or Materials Was Employee Using at Time of Injury?**

**Was Employee Acting Within the Normal Course of Duties?**

Yes No (if No, explain)

**How Could Injury Have Been Prevented?**

| **In Your Opinion** *(check one)*: | **Facts available indicate that this injury is work related and occurred during the course of worker's usual and customary work hours and duties.** | **It is unclear from the available facts known as to whether this injury is work related. Additional information may be necessary to make a determination.** | **The facts available do not indicate that this injury is work related.** |
|---|---|---|---|

### Supervisor Verification

| **Supervisor Signature** | **Printed Name** | **Date** |
|---|---|---|
| | | |

Original To: **Workers' Comp Manager, Tracey Garza, 5150 N. Maple, JA41, Fresno, CA 93740**
Copies To: **Supervisor, Health Center, Sedgwick CMS, Risk Management**