Supervisor Report of Injury

California State University, Bakersfield Foundation

Office of Human Resources
9001 Stockdale Highway Bakersfield, California 93311

Office: (661) 654-2266
Fax: (661) 654-2299

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	Witnesses *(provide name & phone number)*
	am pm	

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: **Human Resources**
Copies To: **Supervisor, Health Center, Octagon Risk Services, Risk Management**