SUPERVISOR’S REPORT OF WORK RELATED INJURY/ILLNESS

COMPLETE THE APPLICABLE QUESTIONS WITH 24 HOURS OF FIRST NOTICE OF INJURY
PLEASE PRINT ALL ENTRIES
SEND REPORT TO HR-WC@SANDIEGO.EDU   Maher Hall 101

EMPLOYEE:

DEPT:  POSITION:

DATE OF INJURY: __/__/__ TIME: ____ AM PM  TIME BEGAIN WORK: TIME: ____AM PM

DATE REPORTED: __/__/__ TIME: ____AM PM  DATE OF HIRE: __/__/__  FULL TIME/PART TIME
(CIRCLE ONE)

LOCATION OF OCCURRENCE: ________________________________

1. Describe the injury/illness in the employee’s words_____________________________________________________
                                           _______________________________________________________________________________________

2. What was the employee doing at the time of the injury/onset of illness? Please describe any unusual conditions
   that contributed to the injury.

                                           _______________________________________________________________________________________
                                           _______________________________________________________________________________________
                                           _______________________________________________________________________________________

3. What was the root cause or series of causes which led to the injury/illness? ________________________________
                                           _______________________________________________________________________________________

4. Was the employee working with another party at the time of the injury: No___  Yes-Provide name(s) and
   telephone numbers of other persons directly involved:
                                           _______________________________________________________________________________________
                                           Also injured? Yes ___ No___
                                           _______________________________________________________________________________________
                                           Also injured? Yes ___ No___

5. Were there other witnesses to the injury: Yes ___ No ___  Not aware of any at this time: _____

   If “yes”:  Name: _______________________________ Phone: _______________________________
             Name: _______________________________ Phone: _______________________________

6. Was this activity part of the employee’s normal duties?  Yes____  No ____  IF “NO”: 6a. Was employee
   instructed to perform this activity? Yes____  No ____  By whom: _______________________________

7. Had the employee been trained on how to perform this job duty?  Yes ___ No ___  NA ___

   Are the training records available for review, if needed?  Yes ___ No ___
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8. Does this activity require the use of Personal Protective Equipment (PPE)? Yes ___ No ___
   If “YES” 8a. Was employee correctly wearing the PPE? Yes ___ No ___
   8b. Had the employee received training on the use of the PPE? Yes ___ No ___

9. Was any equipment, machinery or tool being used by the employee at the time of the injury? Yes ___ No ___
   If “YES” 9a. List the equipment, machinery or tool(s) ________________________________
   9b. Had the employee received training on the use of the above? Yes ___ No ___ Unknown ___
       If yes, are training records available for review? Yes ___ No ___
   9c. Was the equipment/machinery/tool in good working condition? Yes ___ No ___
       Unknown ___
       If “No”, explain why it was being used: __________________________________________
       ____________________________________________________________
   9d. Can the maintenance records be located? Yes ___ No ___ NA ___

10. Have the employee describe to you how and/or why this injury/illness occurred and what they might have done
to prevent it. Record his/her statement here:
       _________________________________________________________________
       _________________________________________________________________
       _________________________________________________________________

11. What will be done to reduce or eliminate the root cause of this incident and prevent reoccurrence? (NA ___)
       _________________________________________________________________
       _________________________________________________________________
       _________________________________________________________________

COMPLETED BY:

MANAGER/SUPERVISOR: ____________________________ TELEPHONE: __________________

TITLE: ____________________________ DEPARTMENT: ____________________________

SIGNATURE: ____________________________ DATE: __/__/___

Please use addition pages as needed to provide all pertinent information regarding this employee injury/illness.

If you have any questions regarding completion of this report, please call Human Resources extension 2737 or 2711

Forward completed report to Department of Human Resources, Maher Hall 101 or email copy to: hr-wc@sandiego.edu

Rev: 7/15