CAL POLY
Facilities Management
& Development
Environmental Health & Safety

WORK RELATED INJURY / ILLNESS REPORT

TO BE COMPLETED BY SUPERVISOR

FAX completed forms within 24 hours to 756-5444; if unable, call 756-5427 immediately

For additional information and resources, please visit https://afd.calpoly.edu/workers_comp/

Supervisor Name (Print)	**Supervisor's Signature**	**Phone Number**	**Date**

Name of Injured Employee	Empl ID:	Department	Personal Ph. Number	Work Extension 756-

Job Title | ☐ State Employee ☐ Volunteer-DOB/ ☐ StudentAsst | Scheduled Work Days S ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ S ☐ | Shift Start Hour ______ ☐ AM ☐ PM | Shift End Hour _____ ☐ AM ☐ PM

Date of Injury/Illness | Time of Injury/Illness Hour ________ ☐ AM ☐ PM | Date of Your Knowledge | Date Claim Form (DWC 1) Given to Employee

Did injury occur on Employer's premises? ☐ YES ☐ NO | Injured at (Bldg/Rm# or Location): ______________

Was the appropriate safety equipment used: ☐ YES ☐ NO

Has employee received proper training: ☐ YES ☐ NO

Were there witness(es)? ☐ YES ☐ NO
If yes, please list Name/Department/Phone:
1. ______________________
2. ______________________

Did injury result in lost time **after the date of injury?** ☐ YES ☐ NO — Last day worked: ______________
Has employee returned to work? ☐ YES ☐ NO — Date returned to work: ______________
If employee died, date of death: ______________

Describe specific activity the employee was performing when event occurred (e.g., Welding seams of metal forms, loading boxes onto truck).

Describe how the injury/illness occurred (e.g. Employee stepped back to inspect work and slipped on scrap metal. As he fell, he brushed against fresh weld, and burned right hand).

Type of Injury (Check):
1. ☐ Reaction to foreign substance/objects
2. ☐ Puncture
3. ☐ Laceration
4. ☐ Contusion
5. ☐ Burn
6. ☐ Fracture
7. ☐ Amputation
8. ☐ Sprain/Strain
9. ☐ Other ______________

Part of Body (Check):
Indicate Right or Left if Applicable: ☐ Left ☐ Right

1. ☐ Head	10. ☐ Wrist	19. ☐ Neck
2. ☐ Face	11. ☐ Hand	20. ☐ Shoulder
3. ☐ Eye	12. ☐ Finger	21. ☐ Groin
4. ☐ Ear	13. ☐ Knee	22. ☐ Other ______
5. ☐ Mouth	14. ☐ Leg	______
6. ☐ Heart	15. ☐ Ankle	______
7. ☐ Back	16. ☐ Foot	______
8. ☐ Trunk	17. ☐ Toe	______
9. ☐ Arm	18. ☐ Hip	______

Note, if injured/ill employee is off work longer than 14 days, it may be necessary to collect State property (e.g. radio, keys, etc).

DID THE INJURY REQUIRE MEDICAL TREATMENT? If yes, complete **DWC-1** *(click for link)*

☐ YES, treatment at: ☐ MED STOP ☐ OTHER: Physician Name/Address/Phone: ______________
☐ SIERRA VISTA EMERGENCY ROOM ☐ HOSPITALIZED (overnight/in-patient): ______________

☐ **NO. THIS IS FOR DOCUMENTATION ONLY -NO** medical Treatment is required, Employee acknowledges this is an Incident Report only and verifies the following:

***I have been advised of the DWC-1 online information or given a DWC-1 claim form. Initials:*___________

- I have **not** lost any time from work beyond the incident date;
- I have been offered medical treatment but decline to see a physician at this time;
- I have been informed that I have one (1) year from the date of this incident to seek medical treatment; and
- I will notify the Workers' Compensation Analyst immediately at (805) 756-5427 if I wish to request medical treatment.

Signature of Employee: ______________________ **Date:** ______________

A copy of this form will be sent to the Department Head