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 http://afd.calpoly.edu/riskmgmt/forms.asp.

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 ☐ AM Hour _____ ☐ PM	Shift End ☐ AM Hour _____ ☐ PM

Date of Injury/Illness	Time of Injury/Illness ☐ AM Hour _____ ☐ 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