Supervisor’s Report of a Work Related Injury/Illness

Instructions: This form is to be completed by the supervisor when an employee is injured or becomes ill due to a work related incident. All questions are to be completed by the supervisor. Be explicit, factual and thorough. Please include all information related to the injury, including any cause that contributed to the claim of injury. If necessary, attach a separate sheet of paper. The completed and signed form must be faxed to 664-4049, Payroll & Benefits, within 24 hours after an injury/illness is reported. For additional information, please call, 664-2664. Individuals in need of a telecommunications relay service may contact the California Relay Service at (877) 735-2929 TTY. Additional reporting guideline can be found at http://www.sonoma.edu/hr/payroll/workers-compensation/.

Employee and Supervisor Information

Employee Name: ___________________________ Employee ID: ___________________________
Department where employee works: _____________________________________________
Home Address: ___________________________________________ Home telephone number: ________________
(Number and Street, City, State, and Zip)
Date and time of injury/illness: _____/_____/_____, _______ a.m. _______ p.m.
Date and time reported to supervisor: _____/_____/_____, _______ a.m. _______ p.m.
Time employee began work on the day of injury: _____ a.m. _______ p.m.
Employee usually works ___ hours per day, ___ days per week, ___ total hours per week
Employee’s usual work schedule: [ ] Monday to Friday ______ a.m. to ____ p.m. [ ] Other _______________________
Date Employee was given Claim for Workers’ Compensation Benefits form (DWC 1): _____/_____/_____

Supervisor’s Name: ___________________________ Campus extension: __________________

Location of Injury/Illness

[ ] On-campus: Near or in what building? __________________________________________
[ ] Off-campus/on SSU Property: Address: ________________________________________
[ ] Off-campus/on University Business: City: ________________________ County: __________ State: ______________

Injury/Illness Specifics

Describe injury/illness (BE SPECIFIC, i.e. sprain, strain, cut, body part): ____________________________________________________________
Specific activity the employee was performing when event or exposure occurred:
__________________________________________________________

How did injury/illness occur?: ____________________________________________________________

What could have been done to prevent this injury?: ____________________________________________

Names of witness(es) to injury/illness: ____________________________________________________
## Vehicle Accidents

Was the employee involved in a Vehicle Accident?  
- [ ] Yes  
- [ ] No

If yes, complete forms STD 270 – Vehicle Accident Report and STD 274 – Review of State Driver Accidents, which are located at [www.orim.dgs.ca.gov/publications/default.htm](http://www.orim.dgs.ca.gov/publications/default.htm). Return completed forms to the Risk Management Office (Salazar Hall, Room 2057) within 48 hours of accident.

### Referral for treatment

Did the injury require medical treatment?

- [ ] No - accident report only
- [ ] Yes, Employee has been referred for treatment to (check one):
  - [ ] Sonoma State University Student Health Center (for first aid treatment)
  - [ ] Kaiser Occupational Health Center, Santa Rosa
  - [ ] Kaiser Occupational Health Center, Rohnert Park
  - [ ] Kaiser Occupational Health Center, Petaluma

{◆ Please call Workers’ Compensation Coordinator at 664-2664 to schedule the appointment.

- [ ] Kaiser Permanente Emergency Room, Santa Rosa
- [ ] Hospital, including name and location ________________________________

Supervisor Signature: ________________________________  
Date: ______________________________

*Sedgwick CMS is the workers’ compensation administrator for Sonoma State University. Our campus Claims Account Executive will contact you and the employee to obtain all necessary information to make a determination about the claim.*

Payroll & Benefits Use Only

Date and time WC Coordinator was notified ____/____/____  
Received by: ___________  
_____ □ a.m.  □ p.m.