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: _____ Campus extension:_____

Home Address:_____ Home telephone number: _____
(Number and Street, City, State, and Zip)

Date and time of injury/illness: ____/____/____ _____ (hour) ☐ a.m. ☐ p.m.

Date and time reported to supervisor: ____/____/____ _____ (hour) ☐ a.m. ☐ p.m.

Time employee began work on the day of injury: _____ (hour) ☐ 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 be done to prevent this injury?:_____

_____

Names of witness(es) to injury/illness: _____

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Supervisor's Report of a Work Related Injury/Illness Continued

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. 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.