Associated Students, California State University, Northridge, Inc.

SUPERVISOR INCIDENT/ILLNESS REPORT FORM

Instructions:

1. Supervisor is to complete this form whenever an employee is involved in an incident that results in an injury (including minor injuries) or experiences a work-related illness, or an accident occurs in which substantive damage to property is incurred.
2. This completed form must be sent to the AS Coordinator of Risk Management & Special Projects and AS Human Resources within 24 hours of knowledge of incident.

General Information		
Employee Name:	Status of Employee: ☐ Full Time ☐ Part Time ☐ Temporary ☐ Student Assistant ☐ Volunteer	
Department:	Job Title:	
Incident Information		
Type of Injury/Illness/Damage:	Date and Time of Incident:	Date and Time Reported:
Job/Activity being performed at time of incident/illness:	Location of Incident/Illness:	Part of Body Affected:
Witness Name: (if any)	Phone Number:	Status: ☐AS Staff ☐Univ. Staff ☐Student ☐Community
Description of incident/illness: (please be specific; identify tasks being performed, tools, equipment, or materials the employee was using)		
Cause of incident/illness: (describe the root cause of accident/illness; consider factors such as unsafe acts, tool or equipment malfunction, or improper training)		
Corrective action taken or recommended:		
Treatment Information		
Treatment provided: ☐ Given first aid ☐ Student Health Services ☐ Outside clinic ☐ Hospital Emergency Room ☐ Not applicable ☐ Employee denied treatment (provide Employee "Waiver of Treatment" form)		
Diagnosis and treatment (if known):	Was Employee provided the DWC-1 form? ☐ Yes ☐ No *If yes, date provided:*	
Did Employee leave work following incident/illness? ☐ Yes ☐ No *If yes, time clocked out:*	Has Employee returned to work? ☐ Yes ☐ No *If yes, date of return:*	

Supervisor: _____ _____ _____
Print Name Signature Date

Reviewed by: _____ _____ _____
Print Name Signature Date