CAL STATE FULLERTON

EMPLOYEE / VOLUNTEER INJURY / ILLNESS REPORT

Case Number

PART I - TO BE COMPLETED BY INJURED/ILL EMPLOYEE/VOLUNTEER (IF ABLE)

Name	CWID	Date of Birth	Extension

Street	City	State	Zip

Division	Department	Supervisor Name	Supervisor Extension

Home Phone Number	Sex ☐ Male ☐ Female	Date Hired	Start Time (am/pm)

Job Title	☐ Full-Time ☐ Part-Time	☐ Volunteer ☐ Student Asst.	For volunteers, provide information on CSUF contact person:

Describe the injury/illness, including what, where, why, how the injury/illness occurred:

Signature (If able)	Date	Report Completed By	Date	Phone Number

PART II - TO BE COMPLETED BY SUPERVISOR (WITHIN 24 HRS OF KNOWLEDGE OF INCIDENT)

Date of Injury/Illness

Date of knowledge of Injury

Time of Injury/Illness

Hour _____ ☐ A.M. ☐ P.M.

Medical Treatment provided by:
☐ St. Jude ☐ First Aid in Department ☐ EMT
☐ Medical Treatment Declined ☐ No Medical Treatment Provided
☐ Other _____

Was employee treated in an emergency room?
☐ Yes ☐ No

Was employee hospitalized overnight as an in-patient?
☐ Yes ☐ No

Name of physician or other health care professional

Address of physician or other health care professional:
☐ St. Jude Heritage Occupational Health Services - (714) 449-6200
2720 N. Harbor Blvd., Suite 130 Fullerton, CA 92835
☐ Other: _____

Volunteer identification form attached?
☐ Yes ☐ No

Describe the injury/illness, including what, where, why, how the injury/illness occurred:

What action(s) have been or will be taken to prevent reoccurrence?

Part of Body (check)
Indicate Right or Left when Applicable

1. ☐ Head	10. ☐ Wrist	19. ☐ Neck
2. ☐ Face	11. ☐ Hand	20. ☐ Shoulder
3. ☐ Eye	12. ☐ Finger	21. ☐ Groin
4. ☐ Ear	13. ☐ Knee	22. ☐ No Injury
5. ☐ Mouth	14. ☐ Leg	23. ☐ Other
6. ☐ Heart	15. ☐ Ankle	
7. ☐ Back	16. ☐ Foot	_____
8. ☐ Trunk	17. ☐ Toe	_____
9. ☐ Arm	18. ☐ Hip	

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 _____

Name of Witness / Dept / Phone#

1.

2.

3.

Scheduled Work Days

S	M	T	W	TH	F	S
☐	☐	☐	☐	☐	☐	☐

Print Supervisor Name

Did injury cause absence from work?
☐ Yes ☐ No ☐ Don't Know

Has employee returned to work?
☐ Yes ☐ No ☐ Don't Know

Supervisor's Signature	Title	Date	Extension
Department Head Signature	Title	Date	Extension

RM, EHIS (12/08)

Please distribute original to Risk Management (CP-700), a copy to EHIS (T-1475) and retain a copy for the department.