

Return to:
 Cal State East Bay
 Career Empowerment Center
 Attn: Internship Coordinator
 25800 Carlos Bee Blvd. - SA 2300
 Hayward, CA 94542
 (510) 885-2789
 cherie.randolph@csueastbay.edu

Form must be completed and returned **within 24 hours or the next business day of injury/illness**
 To be completed by injured worker and supervisor

Employee Information

Name: _____ Male: ___ Female: ___

Home Address: _____ Married: ___ Single: ___

City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____

Social Security Number: _____ - _____ - _____ Date of Birth: ____/____/____

Department in which regularly employed:

Job Classification: _____ Hire Date: _____ Hours work per day: _____ # of days/week: _____

Was another person responsible? ___ Yes ___ No Who was responsible? _____

Witnesses: (Attach written Statements)

Name: _____ Position: _____ Phone: _____

Name: _____ Position: _____ Phone: _____

On date of injury time started work: _____ Time work ended: _____

Injury / Illness Information

Date of Injury / Illness: _____ Time of Day: ___ AM/PM

Where did the injury occur? (Specific Location): _____

What was the employee doing when injury/illness occurred? (Be specific. Tell what and how it happened):

Object or substance that directly injured the employee:

Part of the body affected. (Be Specific: Right hand-Left hand?):

I have verified the employee was at work at the date and time of incident as stated above. ___ Yes ___ No

Confirm if the injury happened at work? ___ Yes ___ No

Did injury/illness cause absence from work? ___ Yes ___ No

Has the employee returned to work? ___ Yes ___ No

Date returned to work: _____

Safety Information

An unsafe condition existed (check all that apply):

- ___ Defective equipment/tools
- ___ Poor housekeeping
- ___ Poor working conditions (lights)
- ___ Slippery/uneven walking surface
- ___ Chemicals (Include MSDS)

An unsafe act resulted from (check all that apply):

- ___ Lack of skill/training
- ___ Inattention
- ___ Unsafe act/horseplay
- ___ other: _____
- ___ Not following safety rules
- ___ Inadequate planning
- ___ Improper work method

Treatment and Filing Claim (check one):

I choose to accept a medical evaluation for treatment and file a claim for the above noted condition and will go to the appropriate medical facility University Enterprises, Inc. has designated.

I chose to decline the medical evaluation for treatment and filing a claim for the above noted condition. I understand that I do have one year from the date of injury to file a Workers' Compensation Claim and by signing this document, I also understand that should I decide to seek medical treatment for this injury, I must immediately notify my supervisor and go to the medical facility University Enterprises, Inc. has designated.

Employee Signature Date

Supervisor Signature Date