

**EMPLOYEE'S REPORT OF OCCUPATIONAL  
INJURY OR ILLNESS**

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**ALL INJURIES, EVEN MINOR ONES, MUST BE REPORTED.** Complete this report within 24 hours of injury or as soon as possible. All questions are important and must be completed in detail.

1. Notify your immediate supervisor as soon as possible of any injury/illness sustained during the course of your work with UAS
2. Obtain medical care from:
  - a. Cal State L.A. Student Health Center; or
  - b. Concentra (9350 Flair Drive, Ste. 102, El Monte, CA 91731) ; or
  - c. Your personal physician (authorized only if you have submitted a Designation of Physician form to Human Resources Department before your date of injury)
3. Within one working day, complete and return to your immediate supervisor:
  - a. Employee's Report of Occupational Injury/Illness
4. Continue with medical treatment as prescribed by the treating medical provider. After each medical visit, submit a copy of your medical status documents to:
  - a. Your immediate supervisor, and UAS/HRD

Upon receipt of the appropriate forms, Human Resources Department will coordinate the claim processing with the insurance provider, the employing department, the medical provider and the employee. Should you require further assistance with this form, please contact USA/HRD at 3-2524 or 3-2530.

**Part A - Personal Information**

Name of Injured: \_\_\_\_\_ Social Security No.: \_\_\_\_\_  
Last Middle First

Address of Injured: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Salary: \_\_\_\_\_

**Part B - Employment Status**

Job Title: \_\_\_\_\_ Department: \_\_\_\_\_

Hire Date: \_\_\_\_\_ Employee Extension: \_\_\_\_\_

Name of Supervisor: \_\_\_\_\_ Supervisor's Extension: \_\_\_\_\_

**Part C - Injury/Illness**

Date of Injury: \_\_\_\_\_ Time: \_\_\_\_\_ a.m./p.m. Date you reported Injury: \_\_\_\_\_

Witnesses (Names and Telephone Numbers):

1. \_\_\_\_\_ 2. \_\_\_\_\_
3. \_\_\_\_\_ 4. \_\_\_\_\_

Over ⇨

Where did the injury/illness occur: \_\_\_\_\_

What were you doing when the injury/illness occurred: \_\_\_\_\_

How did the injury/illness occur: \_\_\_\_\_

Describe the nature of the injury/illness: \_\_\_\_\_

Describe the part(s) of the body injured: \_\_\_\_\_

Was another person responsible: Yes \_\_\_ No \_\_\_ If yes, explain. \_\_\_\_\_

**Part D – Medical Treatment**

Where did you receive treatment?

- \_\_\_ CSULA Student Health Center (323) 343-3301
- \_\_\_ Concentra, 9350 Flair Drive, El Monte, CA 91731 (626) 407-0300
- \_\_\_ Concentra, 3430 S. Garfield Ave, Commerce, CA 90040 (323)722-8481 (**Holidays, Weekend, Late Hours ONLY**)
- \_\_\_ Hospital: Name: \_\_\_\_\_ Address: \_\_\_\_\_
- \_\_\_ Other: Name: \_\_\_\_\_
- \_\_\_ Declined Medical Care

**Part E – Return to Work**

Did you lose at least one (1) full day of work after the date of injury/illness: Yes \_\_\_ No \_\_\_

Did you return to work: Yes \_\_\_ (returned to work on \_\_\_\_\_) No \_\_\_\_\_

What type of work did you return to: Regular \_\_\_\_\_ Modified \_\_\_\_\_

**Part F – Accident Prevention**

Describe the work place and conditions, which may have contributed to the injury/illness and safety devices present: \_\_\_\_\_

What recommendations would you suggest which may correct the condition(s) and/or prevent future injuries/illnesses of the type: \_\_\_\_\_

Employee's Signature \_\_\_\_\_ Date: \_\_\_\_\_