CSUN. CALIFORNIA STATE UNIVERSITY NORTHRIDGE

SUPERVISOR'S ACCIDENT/ILLNESS INVESTIGATION FORM

INSTRUCTIONS:
1. **Supervisor to complete this form whenever an employee is involved in an accident that results in an injury (including minor injuries).**
2. In addition to completing this form, Supervisor must contact EH&S at x 2401 to report the accident as soon as possible, but no later than 8 hours.
3. Copies of completed form should be e-mailed simultaneously to EH&S: ehs@csun.edu and Human Resources: deborah.stewart@csun.edu. Retain original form in department file.

GENERAL INFORMATION

Name of Employee: (print clearly) Last, First, MI		Employer: ☐ CSUN ID#_____ ☐ USU ☐ AS
Work Department:	Job Title:	Status of Employee: ☐ Permanent ☐ Temporary ☐ Student ☐ Full Time ☐ Part Time

ACCIDENT DATA

Type of Injury/Illness:	Date and Time of Injury	Date Reported	Date Employee Received DWC-1 Form

Job/Activity Being Performed at Time of Accident:	Part of Body Affected	Location of Accident

INVESTIGATION

Description of Accident (please be specific; identify tasks being performed, tools, equipment or materials the employee was using):

Cause of Accident (describe the root cause of accident. Consider factors such as unsafe acts, tool or equipment malfunction, or improper training):

Corrective Action Taken or Recommended: (list on separate page if necessary):

Do you feel this is a work-related injury as reported by the employee? ☐ Yes ☐ No (Explain)

TREATMENT DATA

Treatment Provider:
☐ Given First Aid ☐ Student Health Services ☐ Outside Clinic ☐ Hospital Emergency Room

Diagnosis and Treatment (if known):	Has employee returned to work? ☐ Yes ☐ No If yes, date:

Print Name of Supervisor:

Signature: Date: Phone:

Reviewed by Environmental Health & Safety

Signature: Date: Phone: