California State University, Fresno

Print Form

# SUPERVISOR'S REPORT OF WORK INJURY / ILLNESS

ALL INJURIES | ILLNESSES MUST BE REPORTED. Complete this report IMMEDIATELY UPON NOTIFICATION of an on-the-job injury/illness. ALL SERIOUS INJURIES / ILLNESSES MUST BE REPORTED IMMEDIATELY to EHS at 559) 278-7422.

Employee Name # | Social Security # | Phone #:

Address | City | State California | Zip

Department | Job Position/Title | ○ Full ○ Part Time

Supervisor's Name | Phone # | Mail Stop

1. Date and time of injury/illness: | Location

2. Date and time of injury/illness reported to you:

3. Did employee receive the Employee's claim for Worker's Compensation Benefits form (DWC form 1) ○ Yes ○ No

Date provided: Contact Julie Irwin at (559) 278-2125 to send out the DWC1 form

4. Name (s) of witness (es):

5. Injury / illness resulted in: First aid given? ○ Yes ○ No Medical treatment required? ○ Yes ○ No

If yes, please provide name of physician and/or facility where treated

6. Did injury /illness result in disability beyond day of accident? ○ Yes ○ No If yes, give date last worked

7. Describe how the injury/illness occurred

8. Nature of injury/illness/part of body injured

9. What actions, events or conditions contributed most directly to this accident?

10. What could be done to prevent injuries/illness of this type?

SIGNATURE OF SUPERVISOR

DATE

Distribute: Send original to Worker's Compensation Manager, Julie Irwin M/S: JA41 Tel: (559) 278-2125
Please fax to Julie Irwin: (559) 278-4275