Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

MANAGER'S/SUPERVISOR'S REPORT OF EMPLOYEE INJURY OR ILLNESS
CALIFORNIA STATE POLYTECHNIC UNIVERSITY, POMONA

THIS REPORT MUST BE **COMPLETED BY THE MANAGER/SUPERVISOR** WHEN THERE IS NOTICE OR KNOWLEDGE THAT AN EMPLOYEE HAS SUSTAINED A WORK RELATED INJURY OR ILLNESS. SUBMIT THE COMPLETED REPORT TO RISK MANAGEMENT SERVICES WITHIN 1 WORKING DAY OF NOTICE OR KNOWLEDGE OF THE INJURY OR ILLNESS.

THE "EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS" FORM MUST BE GIVEN TO THE INJURED WORKER WITHIN ONE WORKING DAY OF YOUR KNOWLEDGE OF OCCUPATIONAL INJURY OR ILLNESS WHICH RESULTS IN LOST TIME OR MEDICAL TREATMENT BEYOND 1ST AID.

DATE OF EMPLOYER'S KNOWLEDGE/ NOTICE OF INJURY/ILLNESS (mm/dd/yy)	DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM (mm/dd/yy)	**ATTACH THE COMPLETED CLAIM FORM.**

EMPLOYEE NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH (mm/dd/yy)
HOME ADDRESS: (Number and Street, City, Zip)		PHONE NUMBER

SEX: ☐ MALE ☐ FEMALE	OCCUPATION (Regular job title)	DEPARTMENT WHERE EMPLOYED

EMPLOYEE USUALLY WORKS _____ hours per day _____ days per week _____ total weekly hours	EMPLOYMENT STATUS regular full-time part-time volunteer

DATE OF INJURY OR ONSET OF ILLNESS (mm/dd/yy)	TIME INJURY/ILLNESS OCCURRED	TIME EMPLOYEE BEGAN WORK	IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)

UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? YES NO	IF YES, DATE LAST WORKED (mm/dd/yy)	DATE RETURNED TO WORK (mm/dd/yy)	IF STILL OFF WORK, CHECK THIS BOX

LOCATION WHERE EVENT OR EXPOSURE OCCURRED (If on campus specify location)

SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED.
e.g., second degree burns on right arm, tendonities of left elbow, lead poisoning.

EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED,
e.g., acetylene, welding torch, farm tractor, scaffold.

SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED,
e.g., welding seams of metal forms, loading boxes onto truck.

HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY.

NAME AND ADDRESS OF PHYSICIAN TREATING THIS INJURY	PHONE NUMBER
IF HOSPITALIZED AS AN INPATIENT, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, Zip)	PHONE NUMBER

COMMENTS

CORRECTIVE OR PREVENTIVE ACTION TAKEN

NAME OF WITNESS	DO THE FACTS INDICATE THAT THE INJURY HAPPENED AT WORK? ☐ YES ☐ NO ☐ UNKNOWN

SIGNATURE OF MANAGER/SUPERVISOR	EXTENSION	DATE
WORKERS' COMPENSATION COORDINATOR	EXTENSION	DATE

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY.

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