University Corporation at Monterey Bay
100 Campus Center, Bldg 201 Suite119, Seaside, CA 93955
w: 831-582-4301 or 831-5824498
Fax: 831-582-4152

INJURY/ILLNESS INVESTIGATION REPORT

Please complete and return form **within 24 hours or the next business day** of injury/illness.

Employee's Name ____

Working Title __________________________ Work Phone __________________ Home/cell ________________

Department __________________________ Supervisor's Name

_______________________Phone:____________

Employment Status: ____Full Time ____Part Time ____Seasonal ____Temporary

Date of Injury: _______________ Time of Day: __________ AM/PM Day of Week:___________________

Time Employee Began Work _______________ Last Day Worked (Day of Week and Month/Day) ___________

Location of Accident ____

Accident Reported to __________________________________ Date & Time Accident Reported _____________

WITNESSES: (Attach written statements)

Name: ______________________________Position: _____________________ Phone: __________________

Name: ______________________________Position: _____________________ Phone: _________________

Task Being Performed When Accident/Injury/Illness Occurred____

____

____

Describe How the Accident/Injury/Illness Occurred____

____

____

____

Part(s) of the Body Injured/Affected ____

Describe employee's Injury/Illness in Detail____

____

____

Date, Time employee received medical attention *(if applicable)*____

____

Name of Doctor and/or Hospital *(if applicable)* ____

____

Has employee returned to work? ☐Yes ☐No If yes, give date _________________________

What action can be taken, if any, to prevent this type of injury/illness/accident? __________________________

____

____

(Please complete page 2. Thank you.)

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CONTRIBUTING FACTORS TO INJURY/ILLNESS Check all that apply:

___Weather conditions	___Poor housekeeping/clutter	___Unsafe act
___ Lack of skill/training	___Defective equipment/tools	___ Poor design
___ Inadequate maintenance	___Inadequate work space	___Smoke
___ Inadequate planning	___Uneven/wet walking surface	___ Noise
___ Inadequate lighting	___Inadequate protective equip.	____ Fatigue
___Inadequate ventilation	___ lack of enforcement	___ 3rd party
___ Chemicals (Include MSDS)	___ Staffing	___ Dust

___ Other (please explain):____

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 The University Corporation has designated.

☐ I chose to <u>decline</u> 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 the University Corporation has designated.

____

Employee Signature Date

____

Supervisor Signature Date

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