CALIFORNIA STATE UNIVERSITY BAKERSFIELD

California State University, Bakersfield

Supervisor Report of Injury

Office of Human Resources
9001 Stockdale Highway Bakersfield, California 93311

Office: (559) 278-2125
Fax: (559) 278-6995

To be completed by the injured worker's Supervisor. All injuries must be reported other than minor first aid. This form must be completed in full using all information available and returned to the Office of Human Resources immediately after the injury is known. Incomplete or illegible forms will be returned to the originating department.

Injured Worker Information

Reset Section

Name	Position Title	Department Name	Phone Number

Work Schedule Days *(check as needed)*

☐ Mon – Fri or specify days:

☐ Sun ☐ Mon ☐ Tues ☐ Weds ☐ Thurs ☐ Fri ☐ Sat

Scheduled Hours on Date of Injury

From : ☐ am ☐ pm To : ☐ am ☐ pm

# of Hours Per Week

Has Injured Worker Returned to Work?

☐ Yes If Yes, Date Returned _____

☐ No If No, Last Date Worked _____

Specific Location or Area Where Injury Occurred

Address/City

Did Injury Occur on Employer Premises? ☐ Yes ☐ No

Supervisor Information

Reset Section

Name	Title	
Date Injury Was Reported to Supervisor	**Department Name**	**Phone Number**

Medical Treatment

Reset Section

Did Worker Require Medical Treatment?

☐ Yes ☐ No ☐ Unknown

Name of Physician:

Specific Injury *(if known):*

If Medical Treatment Required, How and Where was Treatment Provided?

☐ **Treated Self** (No Medical Treatment Sought) ☐ **Treated at CSUB Student Health Center**

☐ **Treated at Other Location:**

Medical Facility: _____

Street Address: _____

City: _____ **Phone:** _____

How Was Injured Worker Transported to Medical Facility?

Injury/Illness Information

Reset Section

Date of Injury (mm/dd/yy) ☐ Unknown	Time *(blank if date unknown)* : ☐ am ☐ pm	Witnesses *(provide name & phone number)*

Describe How Injury Occurred:

What Equipment or Materials Was Employee Using at Time of Injury?

Was Employee Acting Within the Normal Course of Duties?

☐ Yes ☐ No (if No, explain)

How Could Injury Have Been Prevented?

In Your Opinion *(check one):*	☐ Facts available indicate that this injury is work related and occurred during the course of worker's usual and customary work hours and duties.	☐ It is unclear from the available facts known as to whether this injury is work related. Additional information may be necessary to make a determination.	☐ The facts available do not indicate that this injury is work related.

Supervisor Verification

Reset Section

Supervisor Signature	Printed Name	Date
		February 9, 2022

Reset All

Original To: **Workers' Comp Manager, Julie Irwin, 5150 N. Maple, JA41, Fresno, CA 93740**
Copies To: **Supervisor, Health Center, Sedgwick CMS, Risk Management**