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

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 payment sis guilty of a felony.

Date of Employer's Knowledge/Notice of Injury/Illness:	**Date Employee was Provided the Employee Claim form *(attached completed claim form if available)*:**

Employee Name:	Date of Birth:	Sex: Male Female Non-Binary
Home Address: number and street, city, zip code		Home Phone: Cell Phone:

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:	Time Injury/Illness Occurred:	Time Employee Began Work:	If Employee Died, Date of Death:
Was Employee Unable to Work for at Least One (1) Full Day After date of Injury? Yes No	If yes, Date Last Worked:	Date Returned to Work:	If Still Off Work, Check This Box:

Location where event or exposure occurred (if on campus, specific location such as building and room number)
Specific injury/illness and part of body affected (e.g., foreign object in left eye):
Equipment, materials and chemicals the employee was using when event or exposure occurred (e.g., 12' extension ladder and electric hand drill):
Specific activity the employee was performing when event or exposure occurred (e.g., employee was trimming shrubs):
How injury/illness occurred. Describe the sequence of events, specific the object or exposure which directly produced the injury/illness (e.g., employee reached up to tighten plumbing connection and burned his right hand on a hot water pipe):
Where did employee receive initial medical treatment (Industrial Clinic - Concentra; Emergency - San Dimas Community Hospital, Pomona Valley Medical Center; Predesignated Personal Physician)
Corrective or Preventive Action Taken:

Names of Witnesses:			
Do the facts indicate that the injury happened at work?	Yes	No	Unknown

Manager/Supervisor (print name): ____________________ Extension:

Manager/Supervisor Signature: ____________________

Workers' Compensation Coordinator Signature: ____________________ Extension: 3725

Filing of this report is NOT an admission of liability.
Workers' Compensation, Student Services Building 121-West-2700
http://www.cpp.edu/~workers-comp/

Revised April 2019