Charles Drew University
Supervisor's Report of Work-Related Injury/Illness/Exposure/Near Miss
UNDER NO CIRCUMSTANCES IS THE INJURED EMPLOYEE TO COMPLETE THIS FORM

EMPLOYEE INFORMATION

Name: _____ Employee ID#: _____
Address: _____ Home Telephone: _____
City/State/Zip: _____ Sex: _____
Department: _____ Department Telephone: _____
Department Head: _____ Supervisor: _____

EMPLOYEE INFORMATION

Employee usually works: No. of days per _____week_____No. of hours per day_____ No of hours per week _____
Work Schedule: _____AM ☐ PM ☐ to _____ AM ☐ PM ☐ Shift Work: Yes ☐ No ☐

EVENT INFORMATION

Date of Incident:	Lost Time? Yes* ☐ No ☐ *Dr's note required – Send to HR	Was another person responsible for the Incident? Yes ☐ No ☐
Time of Incident: _____AM _____PM	***Complete the following only if time is lost:** **Date last worked:_____**	Other workers injured? Yes ☐ No ☐
If employee died, date of death:	Still off of Work? Yes ☐ No ☐ *Dr's release required – send to HR	Witnesses? Yes ☐ No ☐ *Complete Part C below
Your date of knowledge of event:	Date returned to work:	Date claim form provided to employee:

Specific injury/illness and part(s) of body affected: (i.e., broken finger on right hand, tendonitis in left elbow, etc.)

What was the employee doing when the incident occurred? (i.e., loading boxes on truck; cleaning classroom, etc.)

What chemicals, equipment, etc., was employee using when the event occurred?

Did the incident occur on the Employer's premises? Yes ☐ No ☐
Location/Department where the incident occurred:

Was the affected person acting in the line of duty? Yes ☐ No ☐

Describe how the incident occurred (if more space is needed, place attach separate sheet of paper):

What steps should be taken to prevent a similar accident/event?

MEDICAL INFORMATION

Check the appropriate box(es):

☐ No Medical Treatment – Accident/Exposure/Near Miss Report Only
☐ Medical Treatment Received at: St. Francis Medical Center
☐ Other – Please complete the follow information:

Physician Name:_____ Address:_____
City/State/Zip:_____ Phone_____
If hospitalized, please complete:
Facility Name:_____ Address:_____
City/State/Zip:_____ Phone_____

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PLEASE COMPLETE PARTS A&B FOR EVERY INJURY/ILLNESS
AND PART C ONLY IF THERE ARE WITNESSES

Employee Name:_____ Employee ID:_____
Date of Injury/Illness:_____ Date Returned to Work:_____
What type of work did employee return to: Regular ☐ Modified ☐

A. MODIFIED WORK – Please check appropriate box(es):

If injured employ is unable to perform full duties, but may return to work on temporary limited duties, is modified work available or can an alternate work assignment be provided?

☐ Temporary modified duties are available –or–
☐ Alternate work assignment available (work other than regular assigned job duties).
☐ No return-to-work plan developed. Request assistance from Human Resources.

If unable to provide modified duties or alternative work assignment, please list reasons:

_____
_____
_____

B. VERIFICATION – Please check one of the following:

☐ I verify that the injury/illness of this claim is work-related.
☐ I am unable to determine if this injury is caused by current employment.
A physician's report will be necessary to verify if injury/illness is related to employee's current employment at CDU.
☐ The facts do not indicate that this claim of injury is work-related. Please investigate.

Please provide below, reasons to support why you believe this claim may not be work-related.

_____
_____
_____

C. WITNESSES: (To be completed only if answering yes to "Witnesses" quested on Page 1

List name(s) of Witnesses:

_____ _____
_____ _____

COMPLETED BY:

Name: _____ **Title:** _____
Signature: _____ **Date:** _____

Risk Management Comments:

_____
_____
_____
_____

Completing this form is not an admission of liability.

Signature: _____ **Date:** _____