CLAREMONT UNIVERSITY CONSORTIUM

Employee's Report

OCCUPATIONAL INJURY/ILLNESS

TO BE SUBMITTED WITHIN **TWO DAYS** OF OCCURANCE.

Name *(print)* | Job Title

1. College | 2. Department | 3. Department Phone

4. Date *of injury/illness* | 5. Approximate Time *of injury/illness* ☐ AM ☐ PM

6. Time *work shift began* | 7. Building *where injury took place* | 8. Floor/Room *where injury took place*

9. Please describe fully how injury/illness occurred and indicate what you were doing at the time. *(describe below)*

10. Please describe the injury/illness *(describe below)*

11. Body part(s) affected | 12. ☐ left ☐ right

13. Type of Accident *(check all that apply)*

☐ Animal/Insect Bite	☐ Collision (car/vehicle)	☐ Foreign Body in Eye	☐ Contact with Hot Object
☐ Electrical Contact	☐ Fall (different/same level)	☐ Material Handling	☐ Repetitive Motion
☐ Contusion (bruise)	☐ Fall (liquid/grease spill)	☐ Strain	☐ Contact with Chemical
☐ Laceration/Puncture	☐ Other *(describe below)*		

14. Were there any witnesses to your injury/illness? ☐ Yes ☐ No | 15. If "Yes," name of person(s)

16. Have you received medical care for this condition? ☐ Yes ☐ No | 17. Do you wish to receive medical treatment? ☐ Yes ☐ No

18. If you have received medical treatment for this condition, please provide the following information: Date Seen | Doctor's Name and Address

19. Have you had a similar condition before? ☐ Yes ☐ No | 20. If so, when?

21. In your opinion, what can be done to prevent such an accident from happening again? *(describe below)*

I HAVE READ THIS STATEMENT AND IT IS TRUE TO THE BEST OF MY KNOWLEDGE.

Signature | Date

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