WORKERS' COMPENSATION AND DISABILITY ADMINISTRATION

THE CLAREMONT COLLEGES SERVICES

Employee's Report

OCCUPATIONAL INJURY/ILLNESS

TO BE SUBMITTED WITHIN 24 HOURS OF OCCURRENCE.

Name *(print)* | Job Title

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

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

6. Time work shift began | 7. Building Name (*where injury took place)* | 8. Is this COVID-19 related?

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

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

101 South Mills Ave., Claremont, CA, 91711
(909) 607-9493 (909) 607-9688 F