MT. SAN ANTONIO COLLEGE MANAGERS REPORT OF EMPLOYEE INJURY/INCIDENT

1100 North Grand Avenue
Walnut, CA 91789-1399
909.274.7500 • www.mtsac.edu

IMPORTANT: This form is to be completed by employee's manager to **investigate**
And provide information concerning this injury and immediately submitted (**within one business day**)
To Risk Management, Building 4-Room 2555

Name of Injured _____ Job Title _____

Department _____ Extension _____

Home Address _____ Telephone _____
Number, Street

_____ Date of Hire _____
City, State, Zip

Date of Accident _____ Hour _____ AM/PM (please circle)

Date Employer First Knew of Accident _____ Reported to: _____

Accident Location _____
(Be specific-building, parking lot, etc. If location not on campus please include address)

What was employee doing at time of injury? _____
(example: loading trucks, emptying trash, etc.)

How did accident/illness/exposure occur? _____

Employee Work Hours:

Hours Per Day _____ Days Per Week _____ Total Weekly Hours _____

Shift hours: _____ A.M./P.M. to _____ AM/PM (please circle)

Employee status – check one

- ☐ Regular Full-Time
- ☐ Regular Part-Time
- ☐ Hourly As Needed
- ☐ Student Hourly Worker
- ☐ Clinical
- ☐ Volunteer

Apparent nature of injury – Briefly describe: _____
(Example: cut, sprain/strain, etc.)

Injured part of body (please check):

- ☐ Head
- ☐ Finger L/R Digit
- ☐ Arm L/R
- ☐ Abdomen
- ☐ Neck
- ☐ Eye L/R
- ☐ Leg L/R
- ☐ Hand L/R
- ☐ Back
- ☐ Chest
- ☐ Face
- ☐ Foot L/R

Did Injury Involve Sharps (Needles)?	☐ Yes ☐ No

Was 911 called? ☐ Yes ☐ No

Name of witness(es) and phone numbers/extensions _____

Was personal protective equipment required? (protective glasses, safety shoes, safety hats, etc.) Was injured employee using required equipment properly? _____

Corrective action taken (modification of a machine, environment, training, etc.) _____

Additional comments _____

COMPLETED BY:

Signature _____ Date _____

Printed name _____ Extension _____

APPROVED BY:

Signature _____ Date _____

Printed name _____ Extension _____

Please have employee complete before returning form to Risk Management:

Employee Description of Accident: _____

_____

_____

_____

Does employee wish to seek medical attention? ☐ Yes ☐ No

If yes, where? (name and address of facility or hospital) _____

COMPLETED BY EMPLOYEE:

Signature _____ Date _____

Printed name _____ Extension _____

Risk Management Use Only:

Salary Rate _____

Comments _____

Incident Only _____

4/2018:rm/sv