California State University SAN MARCOS

CSUSM EMPLOYEE ACCIDENT/INCIDENT FORM

*To be completed **immediately** by management at time of incident or knowledge of incident.*
Upon completion, return the form via email to: shs@csusm.edu and edikitanan@csusm.edu

PERSONAL INFORMATION OF INJURED

Name of Injured			
Relationship to CSUSM: ☐ Staff/Faculty ☐ Student Assistant ☐ Professional Program ☐ Volunteer			
Student ID or Employee ID			
Address	Street	City	State Zip
Phone		Cell Phone	
Email Address			

DETAILS OF INJURY/ILLNESS

Date of Injury/onset of Illness:	Time injury/illness occurred: ☐ A.M. ☐ P.M.	Were other workers injured or became ill in this incident? ☐ Yes ☐ No
Specific injury/illness and body part affected		

Did the incident occur on CSUSM (San Marcos campus) premises: ☐ Yes ☐ No
If yes, provide department/location:
If no, provide location where incident occurred:

Equipment, materials and/or chemicals in use when incident/exposure occurred:

Describe how the injury/illness occurred, include property damage if applicable:

Probable cause/causes:

Witnesses, include name and contact information: Statement Rec'd
_____ ☐
_____ ☐

ACTION TAKEN AT TIME OF INCIDENT

Was medical assistance provided at the time the injury occurred? ☐ Yes ☐ No
If yes, provide a brief description and who provided:

Hospitalized: ☐ Yes ☐ No
If yes, where: _____ Time Admitted: _____ ☐ A.M. ☐ P.M.
Transported by: ☐ UPD ☐ Ambulance/Paramedics ☐ MPP ☐ Self ☐ Other:

COMPLETE THE FOLLOWING IF THE INJURED INDIVIDUAL IS A CSUSM EMPLOYEE

Employee's Title/Occupation			
Department		Supervisor	
Time employee began work on day of injury/illness:		Scheduled hours on day of incident:	
Date of knowledge or notice of injury/illness:	Did the employee notify you of the need to seek medical services? ☐ Yes ☐ No		
Unable to work for at least one full day after date of injury? ☐ Yes ☐ No	Date last worked (mm/dd/yy):	Date Returned to work (mm/dd/yy):	If still off work, check this box: ☐

Reported by: ☐ UPD ☐ Supervisor/Manager ☐ OHR ☐ Other: _____
Reported by Contact: _____ _____ _____
Name Phone Email

Safe Practice violation or corrective action? ☐ Yes ☐ No If yes, Form 5B must be completed within 15 days.

Initial Investigation Performed by: _____
Print Name/Title Signature Date

Attention: This form contains information related to an individual's health and must be used in a manner that protects the confidentiality to the extent possible while the information is being used for occupational safety and health purposes.