University Enterprises, Inc.
SACRAMENTO STATE
6000 J Street
Hornet Bookstore Bldg., Suite 3900
Sacramento, CA 95819-6063

Human Resources
(916) 278-7003
FAX (916) 278-4787
www.enterprises.csus.edu

ACCIDENT REPORT

Please complete and return form **within 24 hours of the next business day of injury/illness.**

To be completed by injured worker and supervisor

Employee Information

Name: ____ Male: ____ Female:_____

Home Address: ____ __ __ Married: ____ Single: ____

____ __________

City: ____ State: ________ Zip: _____

Home Phone #: _________________________________ Work Phone #: ___________ ____

Social Security Number: ________-________-________ Date of Birth: _______/_______/_______ Age: ___

Department in which regularly employed: ____

Job Classification: _________________ Hire Date: ________ Hours work per day: ______

# of days/week: ____ Was another person responsible? ____ Yes ____No

Witnesses: (Attach written Statements)

Name:

________________________Position:_____________________________Phone:______________________

Name:

________________________Position:_____________________________Phone:______________________

On date of injury: Time Began work: __________________ Time work ended: __________________

Injury / Illness Information

Date of Injury / Illness: _____________________________ Time of Day: ____ AM/PM

Where did injury occur? (Specific Location): _______________________________________

What was the employee doing when injury/illness occurred? (Be specific. Tell what and how it happened):

____

____

____

Object or substance that directly injured the employee: ______________________________

Part of body affected. (Be Specific: Right hand-Left hand?): ___________________________

I have verified the employee was at work at date and time of incident as stated above. ___Yes ___No

Do facts indicate the injury happened at work? ___ Yes ___ No

Did injury/illness cause absence from work ___ Yes ___ No

Has employee returned to work? ___ Yes ___ No

Date returned to work: ____________________

Safety Information

An unsafe condition existed (check all that apply):

____ Defective equipment/tools
____ Poor housekeeping
____ Poor working conditions (lights)
____ Slippery/uneven walking surface
____ Chemicals (Include MSDS)

An unsafe act resulted from (check all that apply):

____ Lack of skill/training
____ Inattention
____ Unsafe act/horseplay
____ Not following safety rules
____ Inadequate planning
____ Improper work method
____ Not following safety rules
____ Inadequate planning
____ other: ______________________________

Treatment and Filing Claim (check one):

- ☐ I choose to accept a medical evaluation for treatment and file a claim for the above noted condition and will go to the appropriate medical facility University Enterprises, Inc. has designated.

- ☐ I choose to decline the medical evaluation for treatment and filing a claim for the above noted condition. I understand that I do have one year from the date of injury to file a Workers' Compensation Claim and by signing this document, I also understand that should I decide to seek medical treatment for this injury, I must immediately notify my supervisor and go to the medical facility University Enterprises, Inc. has designated.

____
Employee Signature Date

____
Supervisor Signature Date